Mental Welfare Commission for Scotland

Report on announced visit to:

Ailsa Ward, Stobhill Hospital, Balornock Road, Glasgow, G21 3UW.

Date of visit: 2 March 2023

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 announced visit was carried out face-to-face.

Ailsa Ward is a 20-bedded rehabilitation ward, for those individuals from the Northeast 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 visited this service in June 2021. Following our visit we made four recommendations relating to ensuring requests for treatment forms were requested urgently, medication prescribed was to be legally authorised, that a dedicated therapeutic activity nurse (TAN) was to be available for the ward and for the service to address the lack of single room accommodation for patients.

On the day of this visit, we wanted to meet with patients, follow up on the previous recommendations, and look at ongoing care and treatment, plans for those patients currently awaiting discharge and the overall throughput of patients moving in and out of the rehab setting.

Who we met with

We met with and reviewed the care and treatment of seven patients; we spoke to the family of one patient. This local visit was undertaken using a combination of virtual meetings with the senior manager and staff prior to the visit, and face-to-face contacts on the day. We spoke to the operational manager, senior charge nurse (SCN), occupational therapy staff, members of the nursing staff and the psychiatrist for the ward.

Commission visitors

Justin McNicholl, social work officer

Margo Fyfe, senior manager (practitioners)

What people told us and what we found

At the time of our visit, the ward was at capacity with 20 patients. Many of the patients had complex needs and had been in hospital for a number of years. Some patients had been in the ward for a timescale that is expected with a period of rehabilitation, which is approximately two years, whilst others have been in the service for up to nine years, with no plans for discharge. From our visit, we noted that there were three distinct groups of patients in Ailsa Ward; patients boarding in the ward due to bed pressures on the acute wards across the Stobhill site, patients whose care focused on slow-stream rehabilitation and patients who had longer-term admissions. Many of the patients on the ward were quite mentally unwell and others had considerable physical health needs. There were particular challenges in providing care for such a diverse group of patients and in meeting their very different needs. However, we heard from nursing staff that they felt supported and equipped to do so.

Care, treatment, support and participation

This was an announced and as a result patients, relatives, and staff were prepared to meet with the visiting officers. We were given full access to meet with patients and staff.

The ward has input from one consultant psychiatrist, occupational therapy (OT) and psychology. Input from other professionals included dietetics, speech and language therapy, physiotherapy and podiatry could be arranged on a referral basis. We heard that psychology input was essential to supporting patients and staff. This included regular planned patient formulation sessions, reflective space and cognitive remediation therapy (CRT). This has helped in gaining an understanding of patients' presentations and distressed behaviours.

There was a visiting GP service from a local medical centre that provided three sessions per week and the ward has access to the duty doctor when required. All annual health checks were carried out, along with any other required physical healthcare interventions that included the monitoring of Clozapine and Lithium therapy, high-dose antipsychotic monitoring and diabetic monitoring. Pharmacy staff continued to be available for the completion of medication reviews when required.

Patients expressed mixed views of their experiences in the ward. Some patients were complimentary about the care provided, describing the staff as "caring" and "very supportive". We heard from one patient who told us, "I have nothing but good things to say about them, there is no judging and they care about every patient". Some expressed their frustrations about their lack of progress, "I'd like to get out but my progress is stopping me. I find that very upsetting", while another said, and "I've lost touch with the outside world. There is nothing good here".

Most patients expressed the view that their nearest relative or named person had regular access to the psychiatrist and the wider care team at least once a month. All patients and relatives we spoke with said that they were able to ask open questions about future care planning. A number of patients highlighted the positive aspect of having consistent staff whom they trusted and found to be approachable.

We heard that the recruitment and retention of nursing staff for the ward tended not to be challenging as staff maintained their positions in the ward. Despite this, there remained the

need to use bank staff to ensure adequate cover for the ward was available for each shift. It was positive to note that no agency staff were used in service due to level of staff retention.

During our last visit, a number of patients raised issues regarding the food, the portion sizes or the menu rotation. On this occasion, we heard from two patients regarding their negative experience of the food provided, advising that they were "sick" of the same fortnightly menu rotation. For those patients who find themselves in a rehabilitation ward potentially up to eight years this is understandable. On a more positive note, we were advised that for five days per week, all patients could have access to a budget to cook their own meals in the ward, which ensured the opportunity for patients to have a more varied diet and menu choices.

We were able to observe good social interactions between all patients and staff. During our visit there was a group running where we observed enthusiastic participation from both patients and staff. We were able to speak to patients who advised us of the opportunities to have time out in the local community as they prepared for discharge. We heard from some patients that they had regular access to on-site and off-site community groups, which was a notable improvement from our last visit where activities, particularly in the community remained, were restricted due to Covid-19. The activities available included attendance at technology groups, OT led groups, which include breakfast preparation, "come dine with me" meal sessions and supper groups. We were able to observe a breakfast session during our visit where those involved appeared to be enjoying the opportunity to utilise their skills.

We heard that patients had access to the gym, artwork sessions, pet therapy visits, music in hospital, hairdressing and supportive leave to attend Flourish House, Re-start, Tackling Recovery and the Common Wheel project, which are based in the wider Glasgow area.

In patients' files we found activity timetables, which detailed a weekly structure for most patients. This timetable approach aimed for patients to work together with staff, to ensure that each individual was equipped with the practical skills necessary to allow them the optimal chance of successful rehabilitation.

All patients in Ailsa Ward were subject to the Care Programme Approach (CPA), a multi-disciplinary care management process. This approach was coordinated by a member of staff onsite who ensured that these routinely took place. There was evidence that patients, relatives and advocacy staff participated in these meetings, as well as social workers and mental health officers (MHOs). Care plans and risk assessment documentation were also available.

Patients and staff spoke positively about their access to social work staff from the local Health and Social Care Partnership (HSCP). These links ensured that patients had access to social care staff or support workers in the community to enable timely discharges from hospital. We were informed that there were six patients whose discharge was delayed from the ward, despite there being a clear discharge planning in place. The majority of delays were no longer than three months, with the longest being over one year due to challenges finding suitable supported accommodation.

Multidisciplinary team (MDT)

The ward has multi-disciplinary team (MDT) meetings that includes psychiatry, nursing, occupational therapy, psychology and other professions as and when required. The meetings are held weekly and each patient is discussed and reviewed a minimum of once every four weeks, but more frequently if required. The MDT's paperwork that we reviewed did not always demonstrate clear evidence of forward planning, goal setting, patient's progress on their recovery journeys and clear signposting of the goals required for discharge. We heard from a number of patients that they felt "lost" and they were "not sure what I need to do to move on". We recommend that managers review how the MDT meetings are recorded and ensure they are goal-focused to ensure patients are clear on their role in the recovery pathway.

Recommendation 1:

Managers should ensure that MDT meetings are goal focused and that patients are clear on the summary of any discussions. This includes any progress they are required to make to ensure progress and discharge plans.

Care plans

Nursing care plans are a tool that identify detailed plans of nursing care, ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. During our visit, we saw a range of person-centred care plans which addressed both physical and mental health care needs. The care plans identified needs and agreed rehab goals which included discharge planning. There was evidence of patient participation and where there was non-engagement, reasons were noted. The review dates of the care plans varied widely, and while we found that some care plans were comprehensive for the longer stay patients, some of the plans had not been updated to reflect the current care needs observed. Care plans should ensure participation and support decision-making, with nursing staff being able to evidence how they have made efforts to do this. We would have liked to have seen how individuals and relatives, where involved, were encouraged to participate with care planning and how their views were captured in the care planning process.

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

Recommendation 2:

Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

Patient records

Patient records are held mainly on EMIS, the electronic health record management system used by NHS Greater Glasgow and Clyde (NHS GGC). Additional documents continue to be held in paper files, including nursing care plans. There is a long-term plan in NHSGCC for all patients' records to be held on EMIS but there is no exact date confirmed for the transition to a paperless system. We found patients' records easy to navigate, and there was a clear focus

upon individual patients' mental and physical well-being, with comprehensive physical health reviews in place.

Use of mental health and incapacity legislation

On the day of our visit, 15 of the 20 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 ('CPSA'). The appropriate detention paperwork was readily available for all patients. 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. We found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were recorded correctly with the relevant forms in place. One T3 form was found to require an update due to a change in medication. The Responsible Medical Officer (RMO) for the patient was informed as to how to request this. We found no further issues regarding the required mental health legal paperwork.

Some patients across the wards were subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). In relation to the patients' welfare benefits, this means that the NHS has applied for the Department of Work and Pensions (DWP) appointeeship role to manage patients' welfare benefits. We were heard no concerns from patients in relation to how this was being managed by the hospital.

Some patients in Ailsa Ward had established diagnoses of both mental and physical conditions. It is not uncommon to find a percentage of these patients who lack capacity in relation to their medical treatment. For patients assessed as lacking capacity, a section 47 Certificate under Adults with Incapacity (Scotland) Act 2000 is required to authorise their medical treatment. During our visit, neither we, nor the staff on shift could find any evidence of s47 certificates issued for any of these patients.

Recommendation 3:
Managers and medical staff should ensure that where a patient lacks capacity in relation to decisions about medical treatment s47 certificates, and where necessary, treatment plans are completed in accordance with the AWI Code of practice and cover all relevant medical treatment the individual is receiving.

Rights and restrictions

Ailsa ward operates a locked door and has a policy to cover this. We were satisfied that this was proportionate in relation to the needs of the patients. Although restrictions due to the Covid-19 pandemic have lifted, the ward continues to place the safety of patients at the forefront of anyone who visits the ward with appropriate personal protective equipment (PPE) available.
We were informed that all patients detained under the Mental Health Act were referred to advocacy by their MHO and/or nursing staff. We were pleased to hear that advocacy services have resumed face-to-face visits. Patients that we spoke to had a good knowledge of their legal status and rights, with advocacy input and legal representation where required.

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. We were pleased to note that patients and staff were aware of advance statements and we found clear evidence of these in patient's files.

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

Activities in rehabilitation wards are essential to ensure recovery planning that aids with patients re-integration into the community. We were pleased to hear that occupational therapy (OT) provision is valued as part of this in Ailsa ward; OTs were employed to work flexibility with patients in and out with the ward environment. This resource ensured that there was an offer of support and activities for all patients that focused on discharge planning.
The files we reviewed did not have recordings on what OT assessments were undertaken. During our next visit it would be helpful to have access these recorded in the patient's file. We heard from patients that the range and level of activities was mixed. Some patients felt that the balance was right and that they enjoyed participating in the programmed activities, while others commented that they were "bored" due to the restrictions place upon them.

We heard about the ward's successful bid for a grant to purchase a variety of new activity equipment. This included the purchasing of a new computer console and an air hockey table, with a plan to utilise the remaining monies for a variety of activities and outings in the community. We look forward to hearing from patients how these will help improve their quality of life as an in-patient in Ailsa ward.

On our previous visit, we made a recommendations relating to fact that the ward did not have access to a therapeutic activity nurse (TAN). It was positive to note that since August 2022, a TAN has been employed for the ward on a part-time basis. This input now ensures that there is an equity of service provision with Ailsa ward, which mirrors the other rehab services across the Stobhill site.

Patients and staff whom we spoke with highlighted the positive work undertaken by the OT staff who provide input to the ward. One patient stated "I really enjoy working with the OT. There is always something to do."

The physical environment

The physical environment of the wards unchanged since our last visit. One patient raised a concern about the condition of their window, as the latch was broken and the window could not be closed. This was highlighted to the senior charge nurse who agreed to address this matter immediately as it had an impact on the temperature of the room.

The ward space was bright, spacious, clean, in good decorative order and had a lot of natural light. It was well-furnished and there are 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. It was unfortunate to note that the activity room has to remain shut at all times unless staff are present. This is due to the room containing a sink which is a ligature risk. The senior charge nurse told us that a request had been put in to have this removed so the room could be fully utilised, but to date this has not been progressed. We have asked for an update of action in relation to this, as this would support patients to have easier access to activities.

There was a well-designed secure garden to the rear, and an outside seating area to the side of the ward. Both of these areas were peaceful and used regularly by patients. Unfortunately the condition of the garden has been compromised by the number of cigarette ends found in the garden area. It would appear that there have been no steps taken to address this, and we were concerned about the impact of this, especially for those patients who are non-smokers.

Recommendation 4:
Managers should ensure that the garden area is cleaned and maintained to a reasonable standard.

The ward continues to maintain 12 single rooms and two four-bedded dormitories. Many wards across NHSGGC have been refurbished to provide patients with individual rooms to protect dignity, especially as this group of patients can be in hospital for lengthy periods of rehabilitation. We did not hear from any patients complain of the configuration of the ward. We acknowledged that the staff for the ward have limited influence over changing the dormitories; however, we will continue to keep this under review and revisit this matter during our next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure that MDT meetings are goal focused and that patients are clear on the summary of any discussions. This includes any progress they are required to make to ensure progress and discharge plans.

Recommendation 2:
Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 3:
Managers and medical staff should ensure that where a patient lacks capacity in relation to decisions about medical treatment s47 certificates, and where necessary, treatment plans are completed in accordance with the AWI Code of practice and cover all relevant medical treatment the individual is receiving.

Recommendation 4:
Managers should ensure that the garden area is cleaned and maintained to a reasonable standard.

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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