Mental Welfare Commission for Scotland

Report on announced visit to:

Struan Ward, MacKinnon House, Stobhill Hospital, 133 Balornock Road, Glasgow G21 3UZ

Date of visit: 18 April 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 visit was carried out face-to-face.

Struan ward is a 20-bedded adult acute mixed-sex admissions ward. The ward is based in McKinnon House on the Stobhill mental health campus. The unit provides assessment and treatment for adults who have a diagnosed mental disorder. On the day of our visit there were no vacant beds.

We last visited this service on 3 October 2019 and made recommendations regarding care plans, the stable transfer model, and the garden area. The response we received from the service to our recommendation advised us that the stable patient transfer model was no longer used; different arrangements were put in place because of the Covid-19 pandemic. We were also told that, at that time, there was no option of making the garden area more discreet.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear about how staff have managed and any impact on patient care post-pandemic.

Who we met with

We met with, and reviewed the care of 11 patients, 10 who we met with in person and one who we reviewed the care notes of. We also spoke with three relatives.

We spoke with the service manager, the senior charge nurse, and the charge nurse.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

Without exception all the patients we spoke with praised the staff highly. One patient commented that the staff were “a cracking bunch”. Others told us “staff are nice, they talk to you and take you through the park to the shops”. We heard that “staff are lovely” and that “staff are nice”. There were also very positive comments about the clinical team. One patient said of their consultant, “they’re a good doctor, we get on well, but they are strict with me too”. Another patient said of their consultant “it’s the first time I have been asked what I think”. Staff that we spoke with knew the patient group well. It was good to note that the patients we met with highly praised the staff, one patient commented “this is the real deal.”

There was also positive feedback from the patients about the input from the physiotherapy team. One patient credited the physiotherapy team for their recovery from debilitating mobility issues to being independently mobile again. Another talked of the positive impact of being able to access the gym with structured input from the team.

In the past, we had been concerned about patients who were on the ward for extended periods of time, and whose discharge from hospital had been delayed. We were pleased to hear that at the time of our visit there was just one patient awaiting a move to appropriate community living. This patient’s discharge was being actively pursued by the discharge co-ordinator and the health and social care partnership (HSCP).

Care records

Information on patient care and treatment was held in two ways. There was a paper file as well as the electronic record system, EMIS. EMIS was easily navigated and provided specific information about a patient, for example information about a patient’s detention status. We were aware that discussions have been ongoing with the IT department to ensure that going forward, most information will be recorded on the EMIS system. We noted that as an interim measure there was a list in the paper file detailing where specific information was located.

When we last visited Struan Ward, we found that care plans were inconsistent and did not clearly show the patients’ progress during their admission to hospital. We were pleased to note that these had improved, particularly where patients were involved in their care and treatment. There was also improvement in person-centred recording, particularly in the progress notes, but we felt that further improvement detailing the patients’ needs and care provision was required. On the day of our visit, we discussed our concerns with the senior charge nurse, charge nurse and the service manager.

It was good to see that discharge care plans were in place where appropriate. We also found a good deal of information contained in patient’s one-to-one discussions with their named nurse.

We saw that physical health care needs were being addressed and followed up appropriately, with input from a wide range of professionals.

When we reviewed the care plans, we were unable to locate detailed reviews that targeted nursing interventions and individuals’ progress. There was a clear awareness that reviews

were happening but this was not reflected in the paperwork. We were aware that in the service as a whole, care plans and reviews were being worked on and suggested using the Commission guidance to help in the process. Care plan reviews were noted in the EMIS records but not always replicated in the paper copies of the care plans/reviews. We discussed this with the senior charge nurse, the charge nurse, and the service manager.

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 1:
Managers should ensure care plans are person-centred, and patients participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

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. Staffing remained challenging and there were registered and nursing assistant vacancies on the ward. It was clear from the MDT meeting notes that everyone who was involved in an individual's care and treatment was invited to attend the meetings and provide an update on their views. It was clear to see from these notes that when the patient was moving towards discharge, that community services also attended the meetings. The MDT notes were detailed and informative, noting when the patient was invited to attend, as was their named person or a family member if the patient wished for this.

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. By continuing to hold these meetings in this way, using a hybrid attendance model, this has now been embedded in the ward routine.

Use of mental health and incapacity legislation

On the day of our visit, 12 of the 20 patients in the ward 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 the Adults with Incapacity (Scotland) 2000 Act (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and 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 all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

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.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. There were no patients in this category at the time of our visit.

Rights and restrictions

Struan ward operates a locked door, commensurate with the level of risk identified in the patient group. The keypad number is displayed for exit and/or entry.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There were no patients in this category at the time of our visit.

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

When we are reviewing patient files, we looked for copies of advance statements. The term 'advance 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. We did not see any advance statements on file for patients and encouraged staff to discuss the making of such statements with patients as they are nearing the end of their stay in the unit.

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

Two of the patients we spoke did not have English as their first language. Interpreters had been arranged for both patients and we were also able to gain information about their experience of being detained in hospital in a foreign country.

Activity and occupation

During the pandemic restrictions, some activities out with the unit had to be put on hold. Until recently, the ward had the benefit of a therapeutic activity nurse (TAN) who has since left the service. When we visited, Struan Ward shared a therapeutic activity nurse with another ward

until a new TAN is in post. We saw activities taking place in the ward; patients were participating in arts and crafts and there was an activity planner on display in the main corridor. Whilst many patients commented on positive experiences of getting out for a walk in the park and to the shops, this was dependent on the availability of nursing staff. There were a few who commented that they were quite bored and spent a great deal of time in their bed space watching TV or films on their own personal devices.

Regular input from physiotherapy staff supported regular gym visits, and was one of the activities that was particularly enjoyed, mostly by the male patients.

We discussed the perceived lack of activity by the patients with the senior charge nurse, charge nurse and the service manager. We were told that individual staff with particular skills in supporting activities had been identified; it is planned that they will be able to bring different activities to the ward, including more creative arts and crafts, therapet and physical activity. We look forward to seeing this in place on our next visit.

The physical environment

The layout of the ward consisted of six single rooms, with only one room having an en-suite. There were three shared dormitories with toilet/shower area in them.

There was a lounge area and a separate dining area for the patients; both were bright and spacious. The environment was immaculate, and we were able to see where efforts have been made to soften the public rooms and the corridors with some pictures of Glasgow scenes and the Commonwealth Games and Scottish representation at the 2012 Olympics in London.

We heard how access to the garden from the ward had really helped patients who were experiencing stress and distressed behaviours. A previous recommendation was in relation to the garden space that was at the front of the building and open to both the elements and to the entrance to McKinnon House. We were pleased to see that a separate private garden area had been created at the back of the building, where there was less intrusion from public view. The garden space benefitted from fencing that also shielded the users from the wind and was a pleasant area to sit in. We considered that it was important for patients to have access to outdoor safe space and were pleased to see this improvement to the outside space that was available to patients.

Summary of recommendations

Recommendation 1:
Managers should ensure care plans are person-centred, and patients participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

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.

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