Mental Welfare Commission for Scotland

Report on announced visit to:

Isla Ward, Stobhill Hospital, Balornock Rd. Glasgow G21 3UW

Date of visit: 9 May 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.

Isla Ward is a 24-bedded ward providing care for older people with a functional illness living in the northeast catchment of Greater Glasgow and Clyde Health Board. The ward comprised of 12 single rooms and four bed bays. We last visited this service on 12 April 2022 and made recommendations in relation to auditing of care plans and MDT notes. The response we received from the service was that these issues had been addressed.

On the day of this visit we wanted to follow up on the previous recommendations and to hear how the service is adapting and developing as restrictions from the pandemic are lifted.

Who we met with

We met with, and reviewed the care of seven patients, six who we met with in person and one who we reviewed the care notes of. We also spoke with one carer.

We spoke with the inpatient operational nurse manager, the senior charge nurse and charge nurse.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

Throughout the visit, we saw kind and caring interactions between staff and patients; staff we spoke with knew the patient group well. It was good to note that the patients who we met with praised the staff highly, saying they were very well looked after and commenting that they feel listened to, that staff have time to talk and they never make them feel rushed.

We also heard about the work that was being undertaken to improve each patient's journey. A patient flow meeting had been implemented, involving both in-patient and community team members and care home liaison staff. This has enabled better communication and handover planning for patients. Community staff were encouraged to meet their patient on the ward and assess and discuss what supports they would need on discharge, either to home or to a care setting. Patients were supported to access resources in their local community whilst still on the ward, leading to a better discharge experience for the patient and reducing the likelihood of readmission.

Care, treatment, support and participation

At the time of our visit, the ward had 20 patients in residence, with three patients spending time at home; of these patients, six were boarded in from adult mental health wards and a further five had a diagnosis of dementia and were considered to be inappropriately placed.

On our previous two visits we were aware of significant numbers of adult patients boarding in the ward, which we were told at that time was due to a recent significant increase in pressure on beds across the service, and staffing challenges that had arisen due to increased numbers of staff having to isolate due to Covid-19.

We were advised that this situation has not resolved, and the ward has continued to experience very high levels of boarding patients. However, we were told that the patients who were boarding in the ward were age-appropriate for the older adult service, but that their care had not been transitioned across to the appropriate service, as the protocol for this demanded that the patient remain stable in the community for six months prior to transfer. As a result, these boarding patients remained under the care of an adult psychiatrist. This created additional demands on nursing staff time with nine consultants having patients in the ward.

We heard about the close liaison between Isla Ward and Jura, the dementia assessment unit that ensured that patients with a diagnosis of dementia received the specialist care they required whilst in Isla ward. We were told that were plans to hold meetings involving the senior charge nurses from both Isla and Jura Wards, old age psychiatry community staff and consultants to review the admission process for Isla and Jura Wards to ensure people were admitted to the most appropriate setting for their care needs.

The Commission is aware that there is a review of old age psychiatry provision across NHS Greater Glasgow & Clyde underway, however this has been ongoing for some time with no indication of when there will be any outcome from this. We have previously written to the clinical director for old age psychiatry asking that the protocol for transition to older adult services be reviewed as part of this process, to ensure it is fit for purpose. We have been advised a short life working group has been established to review the protocol

Multidisciplinary team (MDT)

The ward routinely had input from four consultant psychiatrists who covered the catchment area. There is currently input from a further five consultants who have patients boarded into the ward from adult services. There was regular input from occupational therapy (OT), psychology, physiotherapy and pharmacy, who attend multidisciplinary team (MDT) meetings.

However, we were advised that there is only one occupational therapist to provide cover for all old age psychiatry wards in north Glasgow, however adult OT are supporting the wards with assessments; as a result the service was stretched, and delays in this assessment process could impact on each patient's length of stay. We heard that, where it is appropriate, psychology input commences during admission and continued post-discharge, providing continuity of care. Social work engagement had recently improved as heads of service had prioritised early engagement to ensure effective discharge processes. Input from other professionals including, speech and language therapy, and specialist inputs were arranged on a referral basis, however dietetic services were providing telephone assessment and support only as they were no longer based on-site.

MDT meetings were held weekly for each consultant. The ward continued to carry vacant staff nurse posts, resulting in the ongoing use of bank staff, however, there had been successful recruitment to health care assistant posts. Despite the pressures on staff, several nurses have undergone training in the management of stress and distress, phlebotomy and ECGs and one nurse was undertaking a tissue viability course.

Care records

Information on patients care and treatment was held in two ways. There was a paper file, which contained the care plans, AWI paperwork and some risk assessments; the electronic record system EMIS contained all other documentation, including falls and nutrition risk assessments, MDT reviews, chronological notes, and care plan reviews. We heard that having care plans on a different system from the chronological notes and reviews made it more difficult to ensure that there was consistency and continuity across documentation. We were assured that discussions are ongoing with the IT department to ensure that going forward, all information can be saved to the EMIS system.

We had previously made a recommendation in relation to MDT review records. During this visit, we were pleased to find detailed MDT meeting records, including information on who attended, goals, decisions taken, and outcomes. Risk assessments and care plans were reviewed at the MDT meetings and there was evidence of patient and relative involvement.

We found comprehensive risk assessments and person-centred care plans in the files we reviewed. Chronological notes were meaningful and detailed and directly related to care plans. However structured care plan reviews varied considerably with some excellent detailed meaningful reviews, and some simply stating "no change" or "care plan still relevant".

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 regularly audit to ensure care plans are meaningfully reviewed on a regular basis.

Use of mental health and incapacity legislation

On the day of our visit, 11 of the 23 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

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. Certificates authorising treatment (T3) under the Mental Health Act were not in place for two patients we reviewed who required this, and we found one certificate that did not authorise all of the prescribed medication. We were told that requests had been submitted for a designated medical practitioner to review the two patients and complete T3s however these had been submitted sometime after they were originally required. We raised this with the senior charge nurse on the day and followed this up with the consultant.

Where an individual lacked capacity and had a proxy decision maker appointed, either guardian or power of attorney, this was recorded in their file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act 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. We found section 47 certificates in all the files we reviewed where this was required, and there was evidence of proxy decision makers being consulted.

For patients who were receiving covert medication there was a completed pathway in place and all appropriate documentation was in order. The Commission has produced good practice guidance on the use of covert medication at:
https://www.mwcscot.org.uk/node/492

Recommendation 2:
Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.

Rights and restrictions

Isla Ward continue to operate restricted entry, commensurate with the level of risk identified in the patient group. There was a policy and information on how to enter exit the ward was available near the door.

We were told that the ward has open visiting. There are two visiting rooms in the ward reception area, and visitors used the dining and garden areas of the ward. The ward continues to keep a record of visitors to ensure they can alert individuals in the event of a further Covid-19 outbreak in the ward.

We saw posters advising the local advocacy service and found evidence in the care records of advocacy services being accessed by patients.

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 input from two therapeutic activity nurses who provided a comprehensive activity programme. There was activity provision throughout the day, including a wide variety of group and individual activities, such as relaxation groups, quizzes, pamper sessions, reminiscence, musical activities, crafts and games. There were evening and weekend activities, and patients were supported to maintain and develop links to groups in their local community such as singing for the brain, musical memories, football memories, exercise groups and local older adult clubs.

We were pleased to find a comprehensive record of person-centred activity provision in the notes we reviewed, and meaningful recording of participation and outcome of activities.

The physical environment

The ward was bright, spacious, clean and in good decorative order. There were well-designed secure garden facilities that were regularly used by patients and visitors when the weather permitted this. There were two large sitting rooms and a dining room, as well as several smaller quiet spaces, which we noted were well used. Dining arrangements and the seating layout in the lounges had been adjusted to support social distancing. Beds are located in 12 single rooms and a number of small dormitories, all of which are en-suite.

We viewed the new magnetic, partial en-suite toilet doors and found that these were unacceptable from both a privacy and dignity, and safety point of view. When in place, they left very large gaps above and below, which we were told make patients feel exposed and vulnerable. They repeatedly fell off when we attempted to open them; we were told that this often results in patients having to use the toilet with no door in place and there have been several instances of the doors detaching from the frame when leaned on for support by a patient, resulting in the patient falling. There was a very real risk of injury to patients from these doors and the patient's privacy and dignity was compromised when using the toilet. We were told that staff had expressed concerns about these before they were fitted, but their concerns had been ignored. We have since been advised that staff are involved in reviewing the design and identifying safe alternatives. We look forward to seeing these changes implemented on our next visit.

We also heard that there is a blanket policy of no plastic bag liners in bins in patient areas, including toilets. We heard that a number of patients in the ward use incontinence pads, but were able to change these themselves. The absence of bin liners in the toilet area meant that the patient either had to find a nurse to take the pad off them and dispose of it, compromising their dignity, or they place it in the unlined bin, resulting in nurses having to retrieve these,

which could pose an infection control risk. The ward team are currently reviewing practise to ensure patients are able to dispose of pads in a dignified manner.

Recommendation 3:
Managers should review the decision to replace en-suite doors with the magnetic partial doors considering the identified safety risk and impact on patient's privacy and dignity.

Recommendation 4:
Managers should ensure that when implementing a new policy because of health and safety concerns, the wider impacts of any change are fully considered and consulted on.

Summary of recommendations

Recommendation 1:
Managers should regularly audit to ensure care plans are meaningfully reviewed on a regular basis.

Recommendation 2:
Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.

Recommendation 3:
Managers should review the decision to replace en-suite doors with the magnetic partial doors considering the identified safety risk and impact on patient's privacy and dignity.

Recommendation 4:
Managers should ensure that when implementing a new policy because of health and safety concerns, the wider impacts of any change are fully considered and consulted on.

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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