Mental Welfare Commission for Scotland

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

Date of visit: 16 October 2023

Where we visited

Armadale and Broadford Wards are 20-bedded, mixed sex, adult acute mental health admission wards that are based in McKinnon House, on the Stobhill Hospital campus. In Armadale Ward, 16 of the beds are for adult acute admissions and four beds are reserved for the inpatient eating disorder service.

We last visited Armadale Ward on the 1 June 2022, and Broadford Ward on the 14 September 2022. Following those visits, in Armadale Ward we made recommendations regarding Adults with Incapacity (Scotland) Act 2000 legislation, activities, maintenance, and the garden. Broadford Ward had no recommendations on our last visit.

Who we met with

In Armadale Ward we met with and reviewed the care of seven patients. We also met with three relatives.

In Broadford Ward we met with five patients and reviewed their care notes. We also reviewed the file note of one patient we did not meet with.

We spoke with the service manager, the senior charge nurses (SCNs), consultant psychiatrists and several members of the nursing team.

Commission Visitors

Mary Leroy, nursing officer

Mary Hattie, nursing officer

Mike Diamond, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

Across both wards, those that we spoke with were very positive about the care and treatment they were receiving. They were complimentary about input from the medical and nursing staff and allied health professionals (AHPs); we heard that they valued their relationships with the nursing teams.

In Armadale Ward, individuals commented that they "received very good care", and that the nursing staff "worked very hard". We heard that individuals felt included in their care decisions.

Some people commented on not feeling safe in hospital. Some of the issues raised with the Commission staff focused on staffing shortages and the use of agency/bank nurses. We heard that when there were unfamiliar staff on the ward, it could be anxiety provoking at times, also that when some patients were exhibiting higher levels of stress and distress, this could impact on feeling less safe.

We discussed staffing with the senior charge nurse (SCN) in Armadale Ward; on the day of the visit, we were advised that there were a number of nursing staff vacancies in the ward. We heard about the service-wide recruitment drive, and the recent employment of trained nurses. There is an induction programme for the recently employed new staff who will soon join the clinical team, and who are being supported through clinical supervision.

We raised the matter of patient safety at the end of day meeting, reflecting on high levels of acute illness and the distress for some individuals, and the impact this had on others in the ward. The SCN discussed how risk was managed on a day-to-day basis, and also that the team's priority was to ensure that all patients felt safe in the ward.

On the day of our visit, we met with relatives whose family members were in Armadale Ward. The feedback from the relatives/carers that we spoke with was positive. Most told us that they felt their relative was well cared for and that they were mostly happy with their care and treatment. The relatives/carers reported that they felt supported by staff who, they said, had an empathetic and caring approach. We heard that communication with nursing staff was good and that updates on any changes were provided.

In Broadford Ward patients commented that "the hospital feels like a safe bubble, a safe zone". Some patients were very complimentary and appreciative of the ward manager's "leadership" describing them as "very proactive and they get things done". Generally, we heard "nursing staff are on the ball". Patients felt that nursing staff were approachable and keen to "aid their recovery".

In Broadford Ward we were told that they had some "trained nursing staff vacancies", however we heard that new staff have been employed, although they are awaiting a start date.

We also discussed the reconfiguration of the service, as Broadford Ward no longer hosts the Esteem service, which is for people aged between 16 and 35, who appear to be experiencing a first episode of psychosis. Instead, Broadford Ward now accommodates patients who may be homeless and have complex care needs.

On our previous visits to the service, we had heard that consideration was being given to having the eating disorder service located in Armadale Ward, although a dedicated team was required and there would be challenges for the team being co-located in an acute admissions ward. We were advised that the senior managers regularly meet with the eating disorder service team. We were assured that they are in conversation and seeking a solution and a way forward. We were told that the consultant psychiatrist for the eating disorder service and community teams have been providing specific training for staff working with individuals who have an eating disorder.

The senior managers also told us that the services plan to introduce RAID training across both services. This model of intervention focuses on a positive approach to working with disturbed and challenging behaviour. We look forward to hearing more about this on our next visit to the service, and to hear about the impact this training has on the staff team and patient care.

The senior charge nurses commented positively about the input from the ward-based psychologist, and how the teams valued the clinical supervision and reflective practice that was being provided.

Care records

There has been an ongoing phased transition from paper notes to the electronic EMIS information. At the time of our visit, patient care and treatment records were held in two ways; there was a paper file in addition to EMIS. We found information to be easily accessible in both the paper format and on EMIS.

On our previous visit, we were told about the auditing process for the care planning process. The audit is carried out by the senior nurse, and the regular audit process is used to assist with improvement, quality, and governance. On this visit, we found care plans to be person-centred, they covered the full range of mental health needs and were individualised in addressing the individual's physical healthcare needs.

We also noted evidence of patient involvement, with care plans that had been discussed with the individual, and when possible, the care plans were signed. When we were interviewing individuals, they were aware of the focus of the care plans and the respective nursing interventions.

We noted the care plans for the eating disorder service to be of a high standard and found them to be more detailed.

The nursing care plan reviews were meaningful, defining the nursing intervention and patient's progress. We noted that although comprehensive reviews of care took place, that documented the changes to individual care, as well as the impact of the nursing intervention, this information was not used to update the individuals care plan, therefore many of the nursing care plans were not current and dynamic.

On the day of the visit there were two patients, across both wards whose discharge was delayed. We were told about the delayed discharge co-ordinator/team and that their support is instrumental in ensuring a timely discharge for the patient. We heard that discharges were planned in collaboration with patients, family, and the clinical team. Unfortunately, we could

not access the discharge planning notes or respective discharge care plans and raised this at the end of day meeting.

We were pleased to note evidence of one-to-one named nurse sessions in the chronological notes. This intervention was appreciated and valued by the patients we spoke to on the day.

Nursing chronological notes were of a good standard, and there was evidence of liaison with families.

We noted that in both wards the CRAFT risk assessment framework was well embedded into practice, and this was dynamic, with individualised plans that were reviewed regularly, updated, and clearly highlighted relevant areas of risk.

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:
For both Armadale and Broadford Wards, managers should introduce an audit of care plan reviews, ensuring that individual progress and changes documented in the reviewing process, are integrated and reflected in the current care plan.

Multidisciplinary team (MDT)

The wards have a multidisciplinary team (MDT) on site consisting of psychiatrists, nursing staff and patient activity nurses, psychology, dietetics, occupational therapy, pharmacy, and social workers. Referrals can be made to all services as required. The services have a broad range of disciples accessible to the patients. We saw that both patients and families were also invited to attend the weekly meeting.

Individual care was reviewed weekly at the MDT meeting. An MDT pro-forma was in use, which documented all those in attendance. However, in Armadale Ward we found that the attendance record of who was at the meeting was not always consistently documented.

The MDT proforma provided a detailed, holistic review of the individual's care, with a good indication of their presentation over the previous week. We found detailed plans with outcomes clearly recorded.

Recommendation 2:
Managers in Armadale Ward should ensure that the notes from the MDT meeting consistently document who attends the MDT team meeting.

Use of mental health and incapacity legislation

On the day of our visit, 21 of the 39 patients across the wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Those that we met with had a good understanding of their detained status, where they were subject to detention under 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. 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.

In Armadale Ward we also found that two patients had intra-muscular (IM) medication on an as required basis, with the medication authorised on a T2 certificate. In adult acute admission wards, administration of 'as required' IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. Our view is that it is unlikely that a patient would consent to IM medication being given urgently for agitation, as deemed necessary by clinical staff, and consider it to be good practice to have this medication covered by a T3 certificate.

We found that T3 certificates were in place, but on two certificates we found that not all medication was included, and therefore not legally authorised. The senior charge nurse agreed to attend to this matter.

In Broadford Ward 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 their file.

Recommendation 3:
Managers and medical staff in Armadale Ward should audit consent to treatment documentation to ensure that all treatment is lawfully authorised.

For one patient in Armadale Ward, who was subject to a guardianship order under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), we did not find a copy of the order and respective powers. The SCN advised us they would attend to this.

We also found for one patient when a section 47 certificate under the AWI Act was required, the team were unable to locate/access this documentation. 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 Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

The Commission has published an advice note guide about section 47 certificates. It is designed to help nurses and other clinical staff understand about section 47 treatment certificates and what these are, for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2021-10/Scope-LimitationsS47_advice2021.pdf

Recommendation 4:
Managers in Armadale Ward should ensure that section 47 certificates are completed and available and correctly filed in accordance with the AWI Act code of practice (3rd edition).

Recommendation 5:
For both Armadale and Broadford Wards, managers should ensure that training and education is available to staff to promote and enhance their knowledge and understanding of the AWI Act.

Rights and restrictions

Armadale and Broadford Wards continue to operate a locked door with a keypad; this is commensurate with the level of risk identified with the patient group. The unit doors were locked and entry was via a buzzer or keypad. There was a locked door policy and information on this is provided to all patients' families and other visitors.

There were no specified persons on the wards on the day of our visit.

We were told that both wards had access to independent advocacy and legal representation. The wards had contact details for both services, and we were informed that leaflets and information were provided on admission. We also saw that there were advocacy posters displayed on the walls, in both services.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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.

In Armadale Ward, the SCN commented that a patient in the ward had an advance statement, and that this had been helpful, and beneficial to the patient when they were in receipt of treatment on the ward. For one patient in Broadford Ward, there was an advance statement on file.

We encouraged staff to discuss the making of an advance statement as an individual progresses towards discharge and their mental health has improved.

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.

Activity and Occupation

Armadale Ward benefited from having their own dedicated therapeutic activity nurse (TAN). The majority of those that we met with commented positively about the activities in the ward. Many spoke of the walking group, art and crafts, and games.

In Broadford Ward we heard about the new activity room; this room appeared well equipped, and there were some games, activity equipment, and access to a fitness machine.

In the wards, those that we met told us about a variety of activities that were available. We were able to see evidence of what they had participated in recorded in the chronological notes.

One individual highlighted the value of one-to-one nursing sessions that focussed on low intensity psychological interventions, where they were provided with self-help materials to help them manage their symptoms of depression or anxiety, using primarily cognitive and behavioural interventions. They discussed progressive muscle relaxation, mindfulness and grounding techniques, commenting that they were introduced to those interventions on the ward.

We were pleased to see that both wards recorded in the chronological notes if the patient did not want to attend any activity offered.

At the end of day meeting, we heard from senior managers about additional staff employed to the TAN team. They highlighted a recent review of this service and at present they have set this for 2024. The service has been engaging with both carers and patients for this process and told us that some finances have been secured. We look forward to hearing about this development and its impact on patient care on our next visit to the service.

The physical environment

Armadale Ward shares a communal entry with three other wards. The design of the ward is of an older style having been built in 2000, and is now in need of upgrade and painting. We discussed this matter at the end of day meeting, and senior managers informed us that the ward is next on a rolling programme for refurbishment and painting.

The ward was clean and bright and spacious with several rooms that are used for smaller groups as well as a larger area that led out into the garden area.

The bedroom areas in the ward consist of six single rooms all with en-suite facilities, two four-bedded dormitories and one six bedded dormitory; each dormitory has its own shower and toilet.

Broadford Ward was a similar layout to Armadale, however this ward was more recently refurbished and redecorated. The ward was clean, bright, well-decorated and throughout the unit we saw art work that gave the ward a homely feel.

For both wards the garden areas were enclosed. The staff informed us of recent input from volunteers and highlighted the improvements and changes in the garden area.

Summary of recommendations

Recommendation 1:
For both Armadale and Broadford Wards, managers should introduce an audit of care plan reviews, ensuring that that individual progress and changes documented in the reviewing process, are integrated and reflected in the current care plan.

Recommendation 2:
Managers in Armadale Ward should ensure that the notes from the MDT meeting, consistently document who attends the MDT team meeting.

Recommendation 3:
Managers and medical staff in Armadale Ward should audit consent to treatment documentation to ensure that all treatment is lawfully authorised.

Recommendation 4:
Managers in Armadale Ward should ensure that section 47 treatment plans are completed and available and correctly filed in accordance with the AWI Act code of practice (3rd edition).

Recommendation 5:
For both Armadale and Broadford Wards, managers should ensure that training and education is available to staff to promote and enhance their knowledge and understanding of the AWI Act.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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