

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Jura Ward, Stobhill Hospital,  
Balornock Rd, Glasgow. G21 3UW

**Date of visit:** 29 April 2019

## **Where we visited**

Jura Ward provides assessment and care for older men and women with dementia. The ward has 20 beds, comprised of a mixture of single, double and four-bedded dormitory areas, all of which have en suite facilities. We last visited this service on 5 April 2018 and made recommendations relating to care plans, shower facilities, activities and recording of proxy decision makers.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

## **Who we met with**

We met with and or reviewed the care and treatment of seven patients, and three carers/relatives.

We spoke with the charge nurse and members of the nursing team.

## **Commission visitors**

Mary Hattie, Nursing Officer

Anne Buchanan, Nursing Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

The ward has input from four consultant psychiatrists. There is regular psychology input, and the ward has sessional input from occupational therapy. Other allied health professionals are available on a referral basis.

Multidisciplinary team (MDT) meetings are held weekly. We found that the MDT meeting notes varied in quality, some were lacking in detail about decisions made and actions agreed, recording of attendance was inconsistent, and several notes lacked a signature and/or date.

Within the files we reviewed, we found detailed initial assessments and risk assessments were reviewed on a regular basis. Physical health needs were being addressed and care plans were in place for these. However, care plans were not being evaluated on a regular basis.

The quality of care planning for the management of stress and distress varied greatly. We found one excellent care plan based on the Newcastle model. However we found several patients where there was evidence in the chronological notes that they were expressing stress and distress where there was no care plan to address this.

Some of the files we reviewed contained a completed 'Getting to Know Me.' This is a document which records a person's needs, likes and dislikes, personal preferences and background, aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. However, there was little evidence of fuller life story information being recorded. As most patients will move on to further care placements, it is important that this information is recorded and goes with them through their care journey

Ward staff were visible in the ward and engaging with patients throughout our visit. Staff clearly know their patients well and there was a warm, welcoming and calm atmosphere within the ward.

**Recommendation 1:**

Managers should ensure that MDT meetings notes are signed and dated, and contain information on decisions made, and a record of who was in attendance.

**Recommendation 2:**

Managers should ensure care plans are evaluated and updated to reflect changes to the patients' needs and the effectiveness of interventions.

**Recommendation 3:**

Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation, and this should be regularly reviewed.

**Recommendation 4:**

Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement.

The Mental Welfare Commission and Care Commission joint report on the quality of care for people with dementia living in care homes in Scotland can found here:

[Remember I'm still me](#)

**Use of mental health and incapacity legislation**

Where patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), copies of detention paperwork were on file and the Mental Health Act recording sheets provided information on when detention commenced and was due to be reviewed.

Part 16 (s235-248) 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.

Where they were required, we found T3 certificates authorising all prescribed treatment.

In relation to the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), where the patient had granted a Power of Attorney (PoA), we found information advising of this and providing contact details for them. However, whilst it was clear from some files that a copy of the PoA had been requested, this was not available within all the files we reviewed.

Section 47 of the AWI Act authorises medical treatment for people who are unable to give or refuse consent. Under s47 a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity.

We found section s47 certificates in place for the patients whose files we reviewed.

#### **Recommendation 5:**

Managers should ensure that when a welfare proxy is in place for a patient/resident, a copy of the document stating the powers of the proxy should be held within the case notes.

#### **Rights and restrictions**

The ward door is secured and, for reasons of safety, access is controlled by nursing staff. There is information advising on how to leave the ward beside the exit.

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/rights-in-mind/>

#### **Activity and occupation**

The ward has input from an occupational therapist (OT) who mainly undertakes assessments, and OT technicians, who provide a number of group activities, such as walking, gardening, film and reminiscence groups. The ward also has a musician who visits weekly and provides entertainment, and a monthly visit from music in hospitals

There were activity recording sheet within all the files we reviewed; these provided a record of both participation and outcome. However, the amount of activity which is provided is limited as occupational staff work across three wards.

We were advised that, whilst nursing staff do undertake some short informal activity sessions when possible, their ability to contribute to the activity programme is limited as they need to prioritise meeting the clinical needs of their patients.

### **Recommendation 6:**

Managers should consider providing a dedicated activity co-ordinator to ensure that patients have access to a range of activities to meet their needs and provide a meaningful day.

### **The physical environment.**

The ward is bright, spacious and in good decorative order, and there are a number of quiet spaces as well as the large sitting areas. Murals around the ward add interest to the environment as do the memory walls. Some of the displays are maintained by the local museums department and varied over time. We were pleased to see that some of the showers have been altered in line with our previous recommendation.

There is a well-designed secure garden with plenty of seating and this space is clearly well used. There were outdoor games and planters which are used by the gardening group which is organised by the OT.

There is a large room which has been adapted to be a flexible space for recreational and therapeutic activities which also offers opportunities for families to visit patients. We were pleased to observe patients were given a choice of where they would like to sit during meal times. While some patients may enjoy the social aspect of dining with others, there was also consideration some may not. Consequently, smaller tables away from the larger communal areas were utilised.

### **Any other comments**

We were advised that there are five patients who are medically fit for discharge but whose discharge is delayed. Some are awaiting guardianship to provide a legal framework to authorise the move. For others the complexity of their presentation means it is difficult to find a placement which can appropriately meet their needs.

From our discussions with staff, our observations, and review of notes, it was clear that the ward is providing care to patients with very complex clinical needs.

### **Summary of recommendations**

1. Managers should ensure that MDT meetings notes are signed and dated, and contain information on decisions made, and a record of who was in attendance.
2. Managers should ensure care plans are evaluated and updated to reflect changes to the patients' needs and the effectiveness of interventions.

3. Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation, and this should be regularly reviewed.
4. Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement.
5. Managers should ensure that when a welfare proxy is in place for a patient/resident, a copy of the document stating the powers of the proxy should be held within the case notes.
6. Managers should consider providing a dedicated activity co-ordinator to ensure that patients have access to a range of activities to meet their needs and provide a meaningful day.

### **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.

MIKE DIAMOND  
Executive Director (Social Work)

## **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 MWC 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**

telephone: 0131 313 8777

e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

