Mental Welfare Commission for Scotland

Report on announced visit to:

Jura Ward, Stobhill Hospital, Balornock Road G21 3UW

Date of visit: 8 December 2022

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.

Jura Ward provides assessment and care for older men and women with dementia. The ward has 20 beds, and comprised of a mixture of single, double and four-bedded dormitory areas, all of which had en-suite facilities.

We last visited this service on 29 April 2019, and made recommendations relating to care plans, life history information, multidisciplinary team notes, activities and recording of proxy decision makers. The service sent us an action plan in July 2019 setting out how these issues had been addressed.

During this visit we wanted to follow up on the previous recommendations and also to hear how the service was adapting and engaging with the community as Covid-19 restrictions were being lifted.

On the day of our visit the ward had 13 patients. We were told that it was unusual to have so many empty beds. However it was felt that the current patients were benefiting from the being part of a smaller patient cohort.

Who we met with

We met with, and reviewed the care of six patients, who we met with in person. We also spoke with three relatives.

We spoke with the senior nurse manager, the senior charge nurse, charge nurse, consultant psychiatrist, therapeutic activity nurse, and members of the domestic team

Commission visitors

Margo Fyfe, senior manager

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

We spoke with three relatives, who were very positive about the care and treatment their loved one had received, and how the whole team had welcomed and communicated with them during a very difficult period in their life. We heard that staff were proactive in communicating with families and providing updates. They knew their patients well, and managed difficult situations, treating patients with "the utmost respect and love, they really do care about their patients." One relative told us "they gave us our dad back", "he was back to the happy, smiling man I remember". One relative commented that the domestic staff are very much part of the team and always have time for a chat with patients. Throughout our visit we witnessed visitors being made to feel welcome and kind and caring interactions between all of the ward team and patients.

Multidisciplinary team (MDT)

The unit has a broad range of disciplines either in the team or accessible to them, including psychiatry, psychology, physiotherapy, occupational therapy, speech and language therapy, pharmacy and other allied health professionals. The nursing team is led by the senior charge nurse, who is currently undertaking the Dementia Improvement Specialist Lead programme. We heard that there are currently a number of staff nurse vacancies, which the hospital is actively trying to recruit. Two of Jura's staff nurses have completed the stress and distress training to become stress and distress trainers. There are also multiple other staff within the ward trained in delivering stress and distress to the patients with a hope that all staff will have completed the training in the next few months.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and update on their involvement; this included families, who could attend in person or if they do not wish to attend could receive a phone call from the consultant updating them. It was clear to see from these notes that when the patient was moving towards discharge to a care home, there was proactive contact with the care home liaison nurse and the care home team to support a smooth transition for the patient.

Care records and care planning

Information on patients care and treatment was held in a paper file, and on the electronic record system EMIS. Care plans were in the paper files, and the reviews recorded on EMIS. We heard that there are plans to eventually move all records onto EMIS, which would make it much easier to follow patient's progress.

We found comprehensively completed 'getting to know me' (GTKM) forms in the patients' files we reviewed. These contained detailed information relevant to the individuals comfort and care. This document contained information on an individual's needs, likes and dislikes, personal preferences and background, to enable staff to understand what was important to the individual and how best to provide person-centred care whilst they were in hospital. We heard that the ward has been working on a project to improve the completion rate and quality of this document as part of the Dementia Collaborative, a national group working to improve

dementia care. The information from GTKM was reflected throughout the individual care plans.

There were updated risk assessments in place for all the patients whose files we reviewed and the identified risks were addressed in the care plans that covered both physical and mental health needs. The care plans were person-centred, detailed and contained all of the relevant information that gave a real sense of the individual and their needs.

We found excellent person-centred care plans for the management of stress and distress in all the files of the patients whose care we reviewed, some of these included Newcastle Model formulations, This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. Others used a traffic light system to identify potential triggers, how distress may present for the individual, and strategies for de-escalation and management. We heard that the ward is trialling the use of the dementia stress and distress assessment scale to further improve the quality of the care it can provide to patients.

We found recent, meaningful, detailed care plan reviews in the majority of the files we looked at, and where reviews had been undertaken, care plans were updated to reflect new information. However we did find a small number of files where the care plan did not appear to have been reviewed.

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 carry out an audit of the nursing care plan reviews to ensure all care plans are reviewed on a regular basis and updated as required.

Use of mental health and incapacity legislation

On the day of our visit, three of the 13 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All paperwork in relation to their detention was on file and 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. 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.

In relation to the Adults with Incapacity (Scotland) Act 2000 (AWI Act), where the patient had granted a Power of Attorney (POA) the information we found advised us of this, and provided contact details for them. Copies of the POA powers were available in all the files we reviewed and there was evidence throughout the chronological notes of consultation with proxy decision makers in relation to care and treatment.

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. We found completed forms and records of communication with families and proxy decision makers in all the files we reviewed.

For patients who had covert medication in place, a completed covert medication pathway was in place, in line with the Commission's recommendations, and there was detailed information from pharmacy on how to safely administer the medication.

Rights and restrictions

Jura ward continues to operate a locked door, commensurate with the level of risk identified in the patient group. There was clear information beside the entrance to the ward for visitors on how to access the ward and we noted that staff attended promptly to any visitors entering or leaving the ward, ensuring they were welcomed and acknowledged.

The ward has open visiting, with relatives having access to patient's bedrooms to visit should they wish.

We saw posters advertising the local advocacy service in the ward.

Activity and occupation

We met with the therapeutic activity nurse (TAN) assistant who was holding a Christmas themed mindfulness group. We heard about the links that had been made into the local community, with patients currently attending various church groups, musical memories, concerts, pantomimes, dementia friendly cinema sessions, local museums and other community facilities. We also heard about the volunteer activities that in-reach into the ward, including therapet, music in hospitals, restart gardening group, and lingo flamingo, which provided relaxed language lessons for patients and for their visitors if they wish to join in.

There was an activity programme setting out an outline of the group activities for the week, however there was also individual activity programmes for each patient, based on their interests and preferences and the programme was adapted on a day-to-day basis to meet the patient's needs.

The TAN assistant currently works across two wards. We heard of plans to utilise one of the staff nurse vacancies to fund a full time TAN nurse for Jura, to further enhance and develop the activity provision.

The patients whose care we reviewed all had individual person-centred activity plans that were informed by their Getting to Know Me. We found records of activity participation and outcomes in the chronological notes we reviewed.

We were very impressed with the level and variety of activities being provided for patients, however we did note that the ward does not have access to some of the recent technology

such as a Reminiscence Interactive Therapy Activities System (RITA) or an interactive sensory table, which could further support and enhance their activity provision.

The physical environment

The ward was bright, spacious and in good decorative order; the atmosphere was warm and welcoming. There were a number of quiet spaces as well as the large sitting areas. Murals around the ward added interest to the environment as did the memory walls. A range of pictures of local Glasgow scenes had recently been acquired, and these acted as talking points for patients and their relatives. Some of the displays are maintained by the local museums department and varied over time.

There was a well-designed secure garden with plenty of seating. This space was clearly well used; there were outdoor games and planters, which are used by the gardening group, and is organised by the occupational therapist.

There was a large room which was used as a flexible space for recreational and therapeutic activities and could be used for families to visit patients. However, visitors were also encouraged to use the patients' rooms for visits.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure all care plans are reviewed on a regular basis and updated as required.

Good practice

For patients who are being discharged to a care home a 'This is me' document is created. This contains information about the patient's life history and a greater level of detail about their habits, routines, preferences and care needs than is found in the GTKM. Where the individual experiences stress or distress information on the potential triggers for this, what behaviours the individual may use to communicate their distress and what strategies have been found to be effective in managing this are all included. There is proactive communication with the care home liaison nurse and the care home staff, both in advance of transfer and afterwards, to support a positive discharge experience and reduce the likelihood of placement breakdown.

The ward has developed an admission pathway. This is displayed in the duty room as a process map which details all the actions required from admission to discharge, along with who is responsible for carrying these out. Staff advise this has been helpful in ensuring there are no omissions which may impact on care delivery or discharge.

The ward is a member of the Dementia Collaborative, which is a national group working with units across the country and Health improvement Scotland to support improvements in dementia care. As part of this the ward has undertaken a project to improve the completion rate of GTKM documentation. This has led to significant increase in both the completion rate and quality of the information recorded, and its subsequent incorporation into person centred care planning.

We were very impressed by the quality of the care plans we reviewed, which contained a great deal of relevant detailed information, giving a real sense of the individual and addressing their mental and physical health needs and family involvement. We would recommend these as exemplars of good practice.

Service response to recommendations

The Commission requires a response to this recommendation 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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