Mental Welfare Commission for Scotland

Report on announced visit to:

Stobhill Hospital, Elgin Ward, 133 Balornock Road, Glasgow G21 3UW

Date of visit: 18 January 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. This local visit was carried out face-to-face.

Elgin Ward is a 20-bedded adult acute admissions ward. The ward is based on the Stobhill mental health site. The ward was purpose built as a ward for older adults but as a result of the pandemic was utilised as an adult admissions unit where new admissions spend the first five days of their in-patient stay undergoing assessment before moving on to their locality ward. We have not previously visited this service. On the day of our visit the ward was at capacity with all beds occupied.

We wanted to hear how patients and staff have managed throughout the pandemic and to evaluate the effectiveness of this process, post-pandemic.

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 met with one relative.

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

Commission visitors

Anne Craig, social work officer

Susan Hynes, nursing officer

Graham Morgan, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

Throughout the visit we saw kind and caring interactions between staff and patients. Staff we spoke with knew the patient group well. From the patients that we met with, staff were highly praised; other comments were that they were “brilliant”, “staff really help”, with several of the patients commenting that they felt safe in the ward. Others said the staff were busy but would spend time with the patients, which was viewed by them as important. Patients viewed their relationship with staff as key to their recovery. A new therapeutic activity nurse had started and was in the process of setting up activities for the patients that will be patient-led. One patient commented “this is a really healing place”.

We did hear from a patient that there was “nothing to do” but when we reviewed the care records we found that for some, opting to engage with activities was a personal choice, rather than there being a lack of activity for the patients; we heard from another patient who told us that they didn’t need to get involved if they didn’t want to. One patient highlighted the availability of spiritual care for the ward, and acknowledged that this had been crucial to their wellbeing and they found this to be of great value.

Some patients commented that the food “wasn’t great” and portion sizes could be better. We raised this with the SCN and service manager, and were advised that this was a recurrent comment across the site and managers were aware.

As an acute admissions ward almost all patients were acutely unwell, however there were two patients had been on the ward for a considerable time; it was felt it would be detrimental to these patients to move them on to their locality ward. On the day of our visit there were two patients on enhanced observations, and this had an impact on staffing levels. However, we observed a good ratio of staff to patients and the ward, although busy, was calm. We also witnessed unobtrusive observation of all patients on the ward. The atmosphere in the ward was welcoming and we observed that staff engaged well with patients and Commission visitors.

A few patients commented about care being not being as good when there were a high number of bank and agency staff on shift. The SCN advised that they had tried to ensure that they have regular bank and agency staff, who get to know the ward and some of the patients, but the recruitment and retention of trained staff had impacted on the ability to provide regular staff to care for the patients. The ward carried a high number of shifts that required to be covered each week.

Communication with the other mental health wards on site was by daily huddles, held at 9.15am and 4.00pm. This ensured that ward, and overall site safety was supported and was a valuable communication tool for patient and staff safety.

We spoke with one carer on our visit. We heard from the patients that family and carers are able to visit without restriction. If issues were identified to the multidisciplinary team, they actively worked to address any concerns raised by patients and their carers.

We asked about any patients whose discharge is delayed and were advised that at the time of our visit, there were two patients, although one of the patients was expected to move into their own flat in the next week or so after our visit. We heard that colleagues and partners were actively working to seek appropriate accommodation for the other patient.

We were pleased to hear that the ward has been working toward AIMS accreditation, and this was nearing completion. We look forward to hearing about this on our next visit.

Multidisciplinary team (MDT)

The unit has a broad range of disciplines either based there or accessible to them. There was evidence of a multi-disciplinary approach to the care of the patients on the ward, as the patients' length of stay could be as little as five days. As a result of the function of Elgin ward there are 14 consultant psychiatrists providing clinical input to the patient group

It was clear from the very detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and gave an update on their views. This also included the patient and their families should they have wished to attend. We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. Continuing to hold these meetings in this way is ongoing. Family members wishing to attend, but who might not have been keen on using the online facility, were given the opportunity to attend in person.

Care records

Information on patients' care and treatment was held in two ways; there was a paper file and the electronic record system EMIS. In particular, care plans remained on paper but there was evidence in the care records of information that had already been stored on paper. However, on occasions, this was difficult to identify. We also felt that the recording of one-to-one sessions could have been much clearer in the care notes. We discussed this on the day of the visit and were assured that discussions are ongoing with the IT department to ensure that in future, almost all information can be saved to the EMIS system.

Recommendation 1:

Managers should ensure all one to one sessions between a patient and nurse are clearly documented in the care records.

Care plans

We found examples of detailed care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We were pleased to note that care plans evidenced patient involvement. We also found good information contained in patients' one-to-one discussions with their named nurses. We did find that the care plans could have been more person-centred and raised this with the senior charge nurse and the service manager during our visit.

We saw that physical health care needs were being addressed and followed up appropriately when physical health needs were identified.

When we reviewed the care plans we were unable to locate robust reviews which targeted nursing intervention and the individual's progress. We discussed this with the nurses on duty

and the senior charge nurse. We are aware that in the service as a whole, care plans and reviews are being developed on and suggested using the Commission guidance on our website to help in the process. We recommended that an audit of the care plan reviews was carried out to ensure that they reflected the work being done, with individuals towards their care goals, and that the reviews were consistent across all care plans. One patient who was being discharged to their own flat had no discharge care plan in place. We also commented on the requirement for an updated care plan for another longer-term patient.

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 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.

Use of mental health and incapacity legislation

On the day of our visit, nine 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 been provided with details about their detained status where they were subject to detention under the Mental Health Act; some patients were not able to process this information as they were very unwell and there were plans to revisit this at an appropriate time.

All documentation pertaining to the Mental Health Act and the Adults with Incapacity (Scotland) Act 2000 (AWIA), 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; these too 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 the AWIA 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. On the day of our visit there was one patient who had a s47 certificate in place. One patient had a welfare guardianship in place and the guardian was actively involved in the decision made for the patient's care.

Rights and restrictions

Elgin ward operates a locked door policy, commensurate with the level of risk identified with the patient group. The code number for the door was clearly visible and patients and visitors were encouraged to use the code. This was tempered by vigilance from the staff who monitored the activities of the patients, particularly where there was time off-ward permitted.

Sections 281 to 286 of the MHA provide 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. Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place and all paperwork was in order.

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 s274 and s276 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 patients with advance statements on file. We discussed this with staff during our visit and it was felt that as an acute adult admission ward, many of the patients in Elgin would be unable to make an advance statement however, staff were aware of their responsibility to promote these.

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

Elgin Ward has recently appointed a new therapeutic activity nurse (TAN) who worked only with the patients in Elgin. As the TAN was only recently appointed, we heard that they were preparing activities to support the patients with meaningful and therapeutic activity. This post was in the very early stages and we look forward to seeing progress made on our next visit.

The physical environment

Elgin ward is a purpose built 20-bedded unit with all bedrooms being en-suite. It is light, bright and spacious and has a feeling of warmth. The layout of the ward was in a square with a communal garden area in the centre, and bedrooms on either side. There was a large communal space with a nurse's station, but there were other smaller sitting/seating areas around the ward. The dining area for the patients was smaller and would not accommodate all the patients sitting down to a meal at one time; one patient commented the dining room was "very busy". The environment was immaculately clean and we were able to see where efforts have been made to soften the public areas with prints of Glasgow and the surrounding areas, done by a local artist.

The rooms were quite impersonal, with few belongings and little in the way of comfort. Several of the patients we spoke to commented that they were cold at night as they only have blankets and would prefer duvets. We had a discussion with the SCN and service manager about the provision of duvets for the patients but we were told that this is about infection control and duvets are not so easily laundered. The service manager agreed to take this back to the hospital management team.

We heard how access to the garden from the ward really helped patients who were experiencing stress and distressed behaviours. We saw the garden area being well used with patients enjoying fresh air. We did comment that the garden area could benefit from some housekeeping; this was also noted by the SCN and the service manager.

Summary of recommendations

Recommendation 1:
Managers should ensure all one to one sessions between a patient and nurse are clearly documented in the care records.

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.

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