Mental Welfare Commission for Scotland

Report on announced visit to: Struan Ward, MacKinnon House, Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UZ

Date of visit: 9 May 2024

Where we visited

Struan Ward is a 20-bedded unit based in McKinnon House, part of the mental health campus at Stobhill Hospital. The ward provides mental health assessment and treatment. The layout of the ward consists of six single rooms, one with an en-suite and five sharing toilet/shower areas. The ward also has three shared dormitories with a toilet/shower area in each.

On the day of our visit, there were 19 people on the ward, with one person temporarily on pass, and being treated on a general, and there were no vacant beds. The age range of individuals was between 26 and 67 years old.

We last visited this service in April 2023 on an announced visit and made recommendations around care plans being person-centred, consistently reviewed, and involving the individual. The response we received from the service was that auditing of care plans was carried out by managers to ensure reviews were happening and plans were person-centred.

On the day of this visit, we wanted to follow up on the previous recommendations and look at other issues that could have had an impact on care and treatment, including discharge processes and the participation of carers and families.

Who we met with

We met with, and reviewed the care of six people and reviewed the care of three individuals. We also met with two relatives.

We spoke with the service manager (SM), the senior charge nurse, (SCN), charge nurse (CN), and head of adult services.

Commission visitors

Gemma Maguire, social work officer

Mary Leroy, nursing officer

Paul Macquire, nursing officer

What people told us and what we found

We heard from several individuals that we spoke with that staff were 'great' and 'pleasant' and how they felt 'listened' to. We observed warm and caring interactions throughout our visit. During this visit, we found evidence of person-centred and recovery-focused care being delivered to individuals throughout their admission.

Relatives we met with told us how staff are approachable and always happy to listen to views and/or concerns. We heard how staff have continued to listen to relatives' views whilst respecting an individual's wish not to have information shared.

We found person centred-care plans, with the involvement of the individual, carer and/or family, occupational therapy (OT), social work, and community mental health teams.

Since we last visited, we are pleased to hear the service now has access to two social workers via the 'discharge co-ordination' team. We heard from a number of individuals and staff that we met with how this has helped progress assessment of support needs, and discharge from hospital.

Since our last visit we are pleased to report on developments made by the service in relation to the variety and availability of activities for individuals. Several people we met with told us the range of activities on the ward was 'good'.

Care, treatment, support and participation

Care records

During this visit, we observed significant improvements in person-centred care planning. Care plans were regularly reviewed and linked well to multidisciplinary team (MDT) meetings. We found recovery-focussed care plan evaluations, with the views of individuals, their carers, and/or families being fully considered and recorded in plans. Several individuals we met with had a detailed understanding of their goals and reported regular one-to-one time with nursing staff and psychiatrist. Where individuals disagreed with their care and treatment, their views were recorded.

All care plans were accessible and continued to be stored in paper files, whilst other care records were held on the electronic recording system, EMIS. Risk assessments were reviewed in a timely way and updated accordingly. On reviewing files, we found that the recording of continuous interventions covered basic observations but did not evidence the high level of person-centred and trauma informed care that we observed being delivered in practice on the day of our visit. On discussing this with SCN and CN, we were advised the service will be 'rolling out' a new electronic care plan template, as well as guidance on continuous interventions. We heard how this would help ensure all interventions are individualised, as well as improve the quality of recording and security of documents. We look forward to reviewing the progress of this on our next visit.

Multidisciplinary team

Struan Ward has weekly multidisciplinary team (MDT) meetings consisting of nursing staff, psychiatrist, OT, physiotherapy, dietician, junior doctors, pharmacy, and psychology. We were pleased to hear individuals felt involved in meetings, with their views being consistently

recorded. Family members were regularly invited, with their views recorded in the record of the meeting.

We heard from individuals and staff that support from the discharge co-ordination team, including social work, has helped recovery and discharge plans to progress. We were also pleased to hear that links with rehabilitation and community mental health services has helped to support the recovery of individuals after their discharge.

Use of mental health and incapacity legislation

On the day of the visit, 15 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). The legal status of each individual who was subject to the Mental Health Act was clear and accessible.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) under the Mental Health Act were appropriately in place where required and corresponded to the medication being prescribed.

We found one discrepancy in relation to a certificate authorising treatment (T3) under the Mental Health Act, which was missing the prescribed as required intramuscular medication. This issue was discussed with the CN on the day of our visit who agreed to follow this up with the psychiatrist.

Recommendation 1:
Managers should ensure that a review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon timeously.

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 paperwork to be appropriately be in place.

For those people that were under the Adults with Incapacity (Scotland) Act 2000 (AWI Act) we found copies of Power of Attorney (POA), or guardianship certificates that were stored in files, with details of POA or guardians clearly documented.

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. For the individuals that we reviewed, and who required a section 47 certificate, we found these to be completed accurately.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act 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. On the day of our visit, no one was specified under the Mental Health Act.

All individuals we met with were aware of their rights and were either involved with advocacy services or knew how to access this service. We heard of carers and families who were able to access a carers support group in the service and found information for carers being displayed on the ward.

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. Where an individual had completed an advance statement, these were accessible within files. We also heard how the service promotes and supports individuals to complete advance statements during one-to-one time with nursing staff.

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

Individuals we met with told us they had a good choice of activities including cooking groups, arts and crafts, gardening, bus trips, music, and relaxation. We heard how the service is developing therapeutic activities to encourage participation and development of skills, such as individuals playing music during ‘jamming’ sessions.

We are also pleased to hear the service is using video link technology so individuals can access a wider range of activities by remotely joining group activity sessions in neighbouring wards. Activities are available seven days a week, supported by two therapeutic activity nurses. Individuals on Struan Ward have access to laundry facilities and a large occupational therapy kitchen to support life skills and functional assessments in preparation for discharge.

The physical environment

The physical environment was bright and spacious with individual’s artwork on display throughout the ward. Struan Ward has access to a well-maintained open front, garden space that looks onto the car park, as well as a small, enclosed courtyard located at the back of the ward.

Individuals subject to the Mental Health Act and who are restricted to the ward, can only access the courtyard. The courtyard is small and sparse in appearance compared with other enclosed outdoor areas in neighbouring wards. On the day of our visit, no one raised concerns regarding outdoor areas. In discussion with staff, we heard how the enclosed outdoor space is adequate for individuals, however on occasions where more people are restricted to the ward, it can feel challenging to manage. We were advised the service has no plans to review the outdoor space in Struan Ward.

Recommendation 2
Managers should consider a review of the outdoor space in Struan Ward to ensure suitable access is maximised for individuals who are restricted to the ward.

Any other comments

It is clear the current leadership within Struan Ward has helped to develop person-centred practice in the service. We observed files to have auditing checklists and heard from the SCN and CN how care plan audits are consistently carried out during supervising sessions.

We were also pleased to hear that support from the quality improvement nurse, and wider staff training, has ensured care plans are meaningful and individualised with involvement of the person as well as their carer and/or family.

We were told about pressures on the service due to vacancies. We discussed this issue on the day of our visit with SCN and head of service and were advised of ongoing recruitment plans. We were also informed that bank staff are used to support nursing staff vacancies and to provide additional cover during times of increased continuous nursing interventions.

Summary of recommendations

Recommendation 1:
Managers should ensure that the review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon timeously.

Recommendation 2
Managers should consider a review of the outdoor space in Struan Ward to ensure suitable access is maximised for individuals who are restricted to the ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan

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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