**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**

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

**Date of visit:** 6 June 2024

## Where we visited

Elgin Ward is a 20-bedded unit, based on Stobhill mental health campus. The ward provides mental health assessment and treatment. On the day of our visit, there were 19 people on the ward with one vacant bed. A number of individuals in the ward had learning disabilities and/or autism, in addition to experiencing mental health difficulties.

We last visited the service in January 2023 on an announced visit; we made two recommendations around recording nursing one-to-one sessions and ensuring person-centred care plans were consistently reviewed, demonstrating progress towards goals. The response we received from the service was that auditing of care plans and care records was carried out by managers, supported by quality improvement leads and that staff were supported with training and guidance.

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

### Who we met with

We met with and reviewed the care of seven people and reviewed the care of a further two individuals. We also spoke with one relative.

We spoke with the service manager (SM), the charge nurse, (SCN) and operational nurse manager.

### Commission visitors

Gemma Maguire, social work officer

Sheena Jones, consultant psychiatrist

## What people told us and what we found

We heard from several individuals that we spoke with that staff were ‘kind’ and that they felt ‘listened’ to. We observed warm and caring interactions throughout our visit, in a calm and relaxed environment.

We found that staff were supporting individuals with a range of complex needs; they demonstrated empathy, care and understanding. We were informed by managers that there is a shortage of specialist learning disability inpatient beds across the service, and individuals with these specific needs who live in the catchment area and who require inpatient assessment, are usually admitted to Elgin Ward. We heard how staff have developed skills and experience in supporting individuals with more complex needs associated with a learning disability.

We were also told the environment in Elgin Ward, with spacious single ensuite bedrooms, provides individuals who experience communication and/or have sensory needs with a suitable environment compared to other inpatient services with shared dormitories.

Following on from our last visit, we were pleased to find that assessments undertaken upon admission and the recording of one-to-one nursing sessions with individuals were person-centred and detailed.

Several people told us they knew what their individual goals were, having discussed this with nursing staff and/or psychiatrist. While we found some person-centred care plans with the involvement of the individual, their family and/or carer, we did not find these to be consistently reviewed.

We also found that care records did not demonstrate the individual’s progress towards goals, particularly when working towards discharge from hospital. Nursing staff had good knowledge of those they cared for, and could tell us about each individual’s progress, including discharge plans, with involvement of social work and community services.

We were pleased to see a variety of activities on offer, both individually and group-based.

### Care, treatment, support and participation

#### Care records

During this visit, we observed improvements in the recording of nursing one-to-one sessions, and several individuals who we met with told us these were happening regularly. We also found person-centred care plans when someone was first admitted to the service, involving the individual and their family where appropriate. Daily nursing notes were detailed, including observations of the person’s physical and mental wellbeing, as well as an evaluation of what activities they engaged in.

As we noted at the time of our last visit, we continued to find that care plan reviews lacked a person-centred focus or recording of the progress on agreed goals. We found progress notes focused on what staff must do rather than the specific goals that the person wanted to achieve and on how this might be achieved. From the care plans that we reviewed, it was not clear how people could contribute to the development of their own care plans.

During our visit, we were able to speak to an individual who had been in hospital for nearly two years; there had been delays in identifying an appropriate place for them to be discharged to. During their admission, we found that the person had spent most of their time in the ward awaiting a discharge plan, with little evidence that the multidisciplinary team had used this time to work on a range of goals relevant to discharge, such as spending time out with the ward and establishing community activities. This felt like an additional delay for that person.

We discussed the importance of person-centred care plan reviews, to ensure people are being supported to progress in their recovery, with the CN and the SM. We highlighted how this was crucial in supporting someone to be ready for discharge from hospital, and to prevent an unnecessary delay and/or being in a restrictive environment for longer than necessary. Our feedback was welcomed, with assurances this area of practice would be reviewed, audited and training provided to staff where required. We look forward to hearing about this, and seeing progress, on our next visit.

All care plans were accessible and continue to be stored in paper files, while other care records were held on the electronic recording system, EMIS. Risk assessments were reviewed in a timely way and updated accordingly.

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 ensure the audit of the nursing care plan reviews fully reflects progress towards stated care goals and that recording of reviews are person-centred, with participation of the individual.

### Multidisciplinary team

Elgin Ward has weekly multidisciplinary (MDT) meetings, consisting of nursing staff, psychiatrists, occupational therapy, physiotherapy, dietician, junior doctors, pharmacy, and psychology. We were pleased to hear individuals felt involved in meetings, with their views being recorded. Family members were regularly invited, and their views were recorded in the note of the meeting.

We heard from individuals and staff that support from the discharge coordination team, including social work, has helped recovery and discharge plans to progress. We are 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, 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The legal status of individuals 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 in place where required, and corresponded to the medication being prescribed. We found one discrepancy with a certificate authorising treatment (T3) under the Mental Health Act. This issue was discussed with the CN and SM on the day of our visit, who agreed to follow this up with the psychiatrist.

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 that paperwork was in place for this.

For those people that were under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we found copies of power of attorney (POA) or guardianship certificates 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 those individuals that we reviewed who required section 47 certificates, we found two certificates had expired. This issue was discussed with the CN and SM on the day of our visit who agreed to follow this up with the psychiatrist.

**Recommendation 2:**
Medical staff should regularly review and audit all section 47 certificates and T2/T3 forms to ensure individuals have their medical treatment appropriately authorised.

## 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.

We met with one individual who was receiving care and treatment on an informal basis and was subject to continuous intervention. The impact of mental illness on the person’s mental and physical health was clearly recorded in their care record and were impressed to see staff being responsive and compassionate to the individual’s care needs. We heard how staff deescalated distress by using individualised distraction techniques, monitoring and provide reassurance to the person. We were informed that the person lacked capacity in most areas of decision-making and was therefore unable to provide informed consent to their care and treatment in hospital. The Commission visitors were concerned about the lack of legal safeguards in place to protect the person’s rights and to authorise care and treatment in hospital. This was discussed with the service on the day of the visit, and we were advised an assessment under the Mental Health Act would be progressed that day. The Commission will follow up on this issue.

All individuals we met with were either involved with advocacy services or knew how to access this service. We heard how families and/or carers could access a carers support group in the service.

When we are reviewing patients' files, we looked 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 can be 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. No one we met with on the day of our visit had an advance statement in place. We heard how the service promotes the use of advance statement by discussing this at each MDT.

**Recommendation 3:**
Managers should ensure where individuals are unable to consent to their care and treatment in hospital, legal safeguards are fully considered, including the use of the Mental Health Act, to ensure rights are protected and treatment is legally authorised.

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

Individuals we met with told us they had a good choice of activities including arts and crafts, guitar lessons, other music related groups, relaxation and going out for walks. Occupational therapy (OT) assessments were also taking place to support the discharge of individuals. For those with more complex needs, OT and nursing staff provided individualised activity programs based on the person's interests. There was also some evidence of evaluation of the activities in the daily nursing notes.

## The physical environment

The physical environment was bright, spacious and modern in appearance, with 20 ensuite bedrooms. The ward has a large communal area and access to smaller multipurpose rooms which can be used for group and/or one to one activities.

The ward has a communal garden area with seating, which was well maintained.

We met with one individual whose ensuite bathroom had no doors and the sink was blocked with water. The individual raised concerns regarding their privacy and that they were unable to use the sink. These issues had been reported by the person to staff in the days prior to our visit. On discussing with CN, we were advised the bathroom doors are removable for safety reasons, however the person currently in the room was not assessed as being at risk, and the doors had not been replaced since the previous admission. The CN arranged for the doors to be replaced on the day of our visit. We were also advised the blocked sink had been reported to the estates department some days ago, however they had not responded as yet. We were informed by CN that drainage was a long-standing problem due to structural issues and that some individuals caused blockages. The SM escalated the issue on the day of our visit and the estates department attended promptly.

**Recommendation 4:**
Managers should ensure that drainage issues are escalated and resolved timeously to ensure individuals can use facilities safely.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure the audit of the nursing care plan reviews fully reflect progress towards stated care goals and that recording of reviews are person-centred, with participation of the individual.

**Recommendation 2:**
Medical staff should regularly review and audit all section 47 certificates and T2/T3 forms to ensure individuals have their medical treatment appropriately authorised.

**Recommendation 3:**
Managers should ensure where individuals are unable to consent to their care and treatment in hospital, legal safeguards are fully considered, including the use of the Mental Health Act, to ensure rights are protected and treatment is legally authorised.

**Recommendation 4:**
Managers should ensure that drainage issues are escalated and resolved timeously to ensure individuals can use facilities safely.

### 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.

## Contact details

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