Mental Welfare Commission for Scotland

Report on announced visit to: Armadale Ward, Stobhill Hospital, McKinnon House, 133 Balornock Road, Glasgow G31 3UW

Date of visit: 6 June 2017

Where we visited

Armadale ward is a 20-bedded adult acute mixed sex ward. The ward has six single rooms and three bay areas: two female (with four beds) and one male (with six beds). Within the ward there are four beds dedicated to the eating disorder service. The staff told us there are plans for a new service model for the eating disorder provision, and inpatients and community services are under review. The inpatient services have three designated nurses who have specialist experience in working with patients who have an eating disorder.

We last visited this service in July 2016 as part of the Commission's national themed visit to adult acute services in Scotland. The previous visit to this service was an announced local visit in March 2014. We made recommendations about mental health legislation paperwork being up to date, methods of recording and storage, and specified person legislation.

On this visit we wanted to follow up on the previous recommendations and also look at care planning documentation and practice, to ensure it is recovery focussed, and physical health and activities.

The areas identified above that we have focused on are themes identified from our adult acute themed visit report as areas that services need to improve.

Who we met with

We met with and/or reviewed the care and treatment of seven patients.

We spoke with the charge nurse and other nursing staff.

Commission visitors

Mary Leroy, Nursing Officer (visit coordinator)

Mary Hattie, Nursing Officer

Yvonne Bennet, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit there was a situation that was challenging for the staff to manage, due to a patient becoming very distressed. The staff were able to maintain a calm atmosphere ensuring everyone's safety, whilst maintaining dignity and privacy for all involved. All the interactions towards patients we observed were friendly and supportive. We heard positive comments about staff from some patients we met. Staff were knowledgeable about the patients when we discussed their care.

Care plans were person centred and detailed in terms of physical and mental health. There was also some evidence that the patient‘s strengths and abilities were reflected within the care plan. The care plans were reviewed on a weekly basis.

There was evidence of patient involvement in the multidisciplinary team (MDT) meetings and in the compilation of care planning. Entries within chronological notes were generally to a good standard. The notes evidenced a MDT approach to care. There were also clear and informative records of occupational therapy (OT) and psychology input. During interviews patients appeared to have a clear understanding of where they were on their care journey.

There is a MDT meeting once a week. We were informed that most of the patients attended this meeting. The clinical discussions that occur within the meeting are well documented and generated a clear action plan with treatment goals. The MDT meeting is attended by crisis team, support workers and the relevant community team.

The consultants for the service have frequent contact with the ward and patients. We were informed that as well as the weekly MDT meeting there is also another format of a weekly patient review, which is for any other issues that arise: reviewing time off the ward, or if patients and family want to see the consultant outwith the MDT meeting. Staff also told us that the consultant, who supports the patients within the eating disorder service, visits on a daily basis.

The ward informed us that they have implemented the ‘triangle of care standards’. This is applied to practice through ensuring that the family know and have contact with the patient’s named nurse and an information booklet regarding the ward. Within the patient’s notes there is evidence of frequent communication with families, documented telephone calls and evidence of attendance at MDT meetings. On the day of the visit we were unable to meet with any carers.

We asked about the promotion of advance statements within the service. We were informed that the consultants, mental health officers and the nursing team discuss this with the patients. The staff told us that these discussions take place as the patient begins to recover. We saw advance statement booklets on display in the patient areas on the day of our visit. During an interview with a patient, she had a clear understanding of what an advance statement was, and was also keen to write one.

Risk assessments and supporting care plans were reviewed on a regular basis. This was either on a daily basis if required, on a weekly basis by the key nurse and also through the weekly MDT team meeting.

There was comprehensive evidence of clinical psychology assessment and treatment plans. The treatment is delivered on a group and a one to one basis. We were also informed about a recent staff training in mentalisation based therapy (MBT). This has been delivered to senior staff, and there are plans to cascade the training to all of the

staff team. There has also been a commitment from the psychology service to provide supervision for this psychotherapeutic approach in practice.

We saw good attention to physical healthcare needs, a full medical/physical assessment on admission with regular physical health checks monitoring. There was also referral to specialist services if required. The charge nurse (CN) informed us of some of the nursing staff had received further training specific to the care needs of the patients who had an eating disorder, including training in investigations: electrocardiograms (ECGs) and in phlebotomy.

We discussed advocacy and noted that many of the patients had access to advocacy. One patient we interviewed commented that she was unwell when she initially had contact with advocacy but the service had left her some helpful written information. The staff told us that they have good links with the advocacy services, and that referrals are responded to quickly and the service offer a weekly drop in session and individual appointments.

Rights and Restrictions

On the day of our visit, one patient was on constant observations. Staff adhered to national guidelines on the use of observations. Within the file we saw evidence of regular reviews and updated risk assessments. This ensured that patients received care in the least restrictive way possible.

Use of mental health and incapacity legislation

We examined drug prescription sheet and treatment certificates (T2/3), which were in place for all patients who required them. Mental Health Act paperwork and copies of all relevant documentation were within the patient file as appropriate.

We saw that Adults with Incapacity Act guardianship, power of attorney and s47 certificates were in place. There was clear evidence of contact with guardians and attorneys at appropriate times.

Activity and occupation

We were able to talk to patients about the activities on the ward that they had been participated in. There is an occupational therapy unit that inputs into the service providing a range of services including functional assessments, recovery focussed group work and one to one sessions. The OT offer group work to all the wards within McKinnon House: breakfast/snack/lunch group, tenpin bowling, relaxation, quiz, art and crafts, baking and newspaper and discussion groups. The nursing staff within the wards arrange some activities in the evenings and at the weekends. The charge nurse told us this provision is often impacted by what is happening on the ward. If the ward is very busy, it is difficult for nurses to deliver ward activities. The nursing staff state that they are keen to develop and provide more recovery focussed group-work for the patients.

Recommendation 1:

Managers should ensure there is an adequate provision of activities in the evening and at weekends.

The physical environment

We were pleased to see that the ward was clean, bright and well maintained. There were pictures and artwork on the walls, providing more visual interest in communal areas. The main ongoing issue with the environment is that the heating system is difficult to regulate, leading to it becoming overheated in the summer and cold in the winter months. The staff highlighted an issue with the garden space: there is a garden fence but there is no gate to enclose the space. This offers little privacy for the patients due to the area being so open and close to the road. For reasons of safety, the staff state it is difficult to leave the ward door open for patients to freely access the garden area. A garden gate would assist with defining the space and making it more accessible to all, whilst ensuring safety.

Recommendation 2:

Managers should ensure that the garden area is maintained and provides a safe, pleasant and easily accessible area for patients and visitors.

Summary of recommendations

1. Managers should ensure there is an adequate provision of activities in the evening and at weekends

2. Managers should ensure that the garden area is maintained and provides a safe, pleasant, and easily accessible area for patients and visitors.

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.

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