Mental Welfare Commission for Scotland

Report on an unannounced visit to: Ward 1, Parkhead Hospital, 81 Salamanca Street, Glasgow G31 5ES

Date of visit: 24 May 2017

Where we visited

Ward 1 is a 20 bedded adult acute mixed sex ward. The ward is situated within Parkhead Hospital. The ward has six single rooms with ensuite facilities and a three bedded bay areas, one bay with six beds and the other two bays with four beds.

We last visited this service in July 2016 as part of the Mental Welfare Commission's national themed visit to Adult Acute services in Scotland. The previous local visit to this service was in February 2014 and was an announced visit. At that time we made recommendations about care planning; the named nurse system; patient activity and the environment.

On this visit we wanted to follow up on the previous recommendations and also look at recovery focussed care planning, patient involvement, physical healthcare and the environment. There are plans for ward one to move to a refurbished ward in Stobhilll Hospital. We were keen to hear how these plans were progressing.

The areas identified above that we have focussed on are themes identified from our Adult Acute themed visit report 2017 as areas that services need to improve.

Who we met with

We met with and reviewed the care and treatment of five patients. This was an unannounced visit and we did not meet with any carers on the day.

We spoke with the senior charge nurse and other nursing staff.

Commission visitors

Mary Leroy, Nursing Officer

Claire Lamza, Nursing Officer

Yvonne Bennet, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

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.

Documentation and care plans

Some of the care plans that we reviewed on the day were disorganised and items were not being consistently filed in order.

We reviewed the patients' care plans. Some were person-centred containing individualised information and identified interventions and care goals. However others varied in quality and did not focus on recovery.

There was some evidence of patient involvement in the multidisciplinary team (MDT) meetings and in the compilation of care planning. Entries in the chronological notes were generally to a good standard, especially where therapeutic one to one time was recorded. We were also informed by the nursing staff that the patients have a community meeting on a fortnightly basis.

The MDT meets once a week. The team uses a template that gives guidance on all components of the meeting to ensure a holistic review of the patient's needs, strengths and goals. It is completed by the professional who is contributing to the review. The clinical discussion that occurs within the meeting is well documented and it generates a clear action plan with treatment goal, although as previously noted this is not always translated into the individual care plans.

The staff informed us that there is regular contact with carers. The ward reports they have implemented the 'triangle of care standards'. This is applied into practice through an initial letter to the carer informing them of the named nurse, and an information booklet about the ward. The carers are also encouraged to complete a brief assessment and within the patient file there is also a relatives and carers contact sheet. Our visit to the ward was unannounced and we were unable to meet with family/carers.

Within the patients' notes we examined we found good evidence of comprehensive psychology assessments. This service is delivered on a one to one basis. The charge nurse also commented that there had been some discussion with psychology to explore the option of delivering some therapeutic group work. However, we were informed on the day of our visit that the psychologist is on maternity leave. The service provides care for patients with complex care needs and we would suggest that managers review the current lack of psychology input.

We saw good attention to physical health care needs: full physical examination on admission to the ward; routine physical health monitoring bloods, vital signs and weight; referrals to specialist services if required and also evidence in notes of patient referral to the national screening services.

Recommendation 1:

The ward manager should review care planning documentation to ensure it is recovery focussed, organised and current.

Recommendation 2:

Hospital managers should review psychology input into the ward to ensure that all patients have access to psychology services if required.

Use of mental health and incapacity legislation

The copies of the certificates authorising detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) were not in the patients' notes. The Greater Glasgow and Clyde care plan documentation sheet for information on legislation was also inaccurate in the files we reviewed on the day and did not reflect patient's current legal status.

We examined drug prescription sheets. Consent to treatment certificates (T2) and certificates authorising treatment (T3) were in place for all patients who required them. They were filed with the patients medication chart, enabling easy checking and reference to be made

We discussed if any patients were subject to Adults with Incapacity (Scotland) Act 2000 (AWI) legislation. The local authority was in the process of a guardianship application for a patient. We highlighted the potential need for a section 47 certificate to authorise physical healthcare for patients who lacked capacity for decision making in this area. The charge nurse informed us that the clinical team would review this situation.

We observed within the files that two patients had their funds managed under Part 4 of the AWI Act.

Recommendation 3:

The ward manager should audit patients' notes to ensure the most recent MHA documentation is on file, and that the Greater Glasgow and Clyde care plan for legislation is updated to reflect accurately the individual's legal status.

Rights and restrictions

On the day of the visit three patients were on constant observations. Two of the patients had been on this high level of monitoring for a protracted period of time. We reviewed the files and discussed the observation levels with the senior charge nurse. Staff adhered to the current national guidelines on the use of observations. Within the individual files we evidenced regular reviews and updated risk assessments. This ensured that patients receive care in the least restrictive way possible.

Four patients were identified as having their discharge delayed. We plan to write to respective local authorities to seek an update on plans for two of the above identified

patients. Overall staff reported difficulties in accessing and sustaining social work interventions for patients, which impacted on forward planning for discharge.

We enquired regarding the transfer of patients between Wards 1 and 3 within the hospital. We were informed that this did happen but it was managed sensitively with consideration to the patient's needs. On reviewing the care plans we did find evidence of this occurring and we are concerned regarding the impact this practice would have on the both consistency of care and recovery.

We discussed advocacy services and noted that many of the patients had access to advocacy. We observed in notes when advocacy services had been offered and declined by patients. There were advocacy leaflets visible within the ward setting. The staff comment that they have good links with the advocacy services. Referrals are responded to quickly and the service is delivered on a one to one basis.

Recommendation 4:

Hospital managers should review the current practice of boarding out of patients to other areas, to minimise the risk of inconsistent delivery of care.

Activity and occupation

The patients we met with were generally positive about the activities and groups on offer and able to discuss the activities they participated and enjoyed. The daily activity programme is displayed prominently in the ward.

The ward activities are provided by occupational therapists (OT) and therapeutic activity nurses (TAN). We found a good range of activities with some emphasis on encouraging people to be physically active. Some activities were delivered in the ward others in the activity room downstairs, also some physical activity groups were delivered outwith the ward setting. Within the patients' files we examined there was good evidence of comprehensive OT assessments and reports, and also the delivery of treatment on a one to one basis.

The OT and TAN work jointly to deliver recovery focussed group work: psychosis, education managing low mood/ anxiety and recovery work. We were informed that these groups were delivered on the basis of patient need. The charge nurse commented that the delivery of education managing low mood and anxiety, and recovery and discharge planning, was also offered to the patients on a one to one basis.

At weekends activities are led by ward staff. This provision is often dictated by clinical need; if the ward is very busy it is difficult for the nurses to deliver ward activities.

Recommendation 5:

Hospital managers should ensure there is an adequate provision of activity at weekends.

Environment

We appreciate that the service plans to move in February 2018. However, we observed on the day that the environment within the ward was stark and all the paintwork needed to be refreshed.

One of the toilet and shower rooms in the bay bedroom was marked with cigarette burns on the flooring. The bay bedrooms look dated in comparison with accommodation available in newer acute psychiatry wards. The bedrooms had minimal opportunity for privacy, with each area divided by paper curtains. There was no provision for secure storage facilities in the bed areas. We viewed a large cupboard with individualised spaces for the patient's valuables, to which the patients could gain access by asking staff. The ward windows were difficult to see through due to colouration in glass and were also in need of cleaning. The curtains were unkempt and hanging off the rails. On the day of our visit we were informed that one of the lifts to the ward was broken. This presents as a much neglected and dismal environment for patients to be cared within.

Recommendation 6:

Hospital managers should audit the environment as a matter of urgency to ensure that it is fit for purpose.

Any other comments

We were updated on the day of plans for Wards 1 and 3 to move to the Stobhill campus into a refurbished ward. We briefly discussed some of the concerns regarding this move and its impact on patients, carers and staff. The provisional date for the move is February 2018.

Hospital managers are requested to update the Commission regarding the timescales and action plan for the move to the Stobhill campus.

Summary of recommendations

1. The ward manager should review care planning documentation to ensure it is recovery focussed and organised and current.
2. Hospital managers should review psychology input into the ward to ensure that all patients have access to psychology services if required.
3. The ward manager should audit patients' notes to ensure the most recent MHA documentation is on file, and that the Greater Glasgow and Clyde care plan for legislation is updated to reflect accurately the individual's legal status.
4. Hospital managers should review the current practice of boarding out of patients to other areas, to minimise the risk of inconsistent delivery of care.
5. Managers should ensure there is an adequate provision of activity at weekends.
6. Hospital managers should inspect the environment as a matter of urgency to ensure that it is fit for purpose.

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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