

Mental Welfare Commission for Scotland

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

Date of visit: 30 April 2018

Where we visited

Armada ward is a 20-bedded adult acute mixed-sex ward. The ward is based in MacKinnon House at the Stobhill Hospital campus. Sixteen of the beds within this service are for adult acute admissions and four of the beds are reserved for the inpatient eating disorder service. We last visited this service in June 2017 and made recommendations regarding the physical environment and the lack of weekend and evening activities.

On the day of this visit, we wanted to follow up on the previous recommendations, and also look at physical healthcare provision, activities and patients' participation in their care.

The above areas were identified in our adult acute themed visit report as areas that services need to improve.

Who we met with

We met with and reviewed the care and treatment of seven patients. We were unable to meet with any carers or family members.

We spoke with the senior charge nurse (SCN), other members of the nursing team and a worker from the advocacy service.

Commission visitors

Mary Leroy, Nursing Officer and visit coordinator

Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit, we were able to meet with seven patients. They told us that staff were professional, approachable, engaged well and were supportive. Some of the patients commented on the supportive leadership within the ward. Staff were knowledgeable about the patients when we discussed their care. It was apparent that the team provided person-centred care.

There was a detailed medical assessment of each patient by the medical staff on file. These assessments are completed within 24 hours of admission, and are of a high standard.

Care plans were personalised and regularly reviewed along with a comprehensive assessment of risk.

There was a daily safety brief which enabled the three wards within MacKinnon House to prepare for the day. During the 15 minute brief they allocated resources and ensured that all relevant information was captured and shared within all the teams.

We saw good attention to physical health care needs: full physical examination on admission to the ward; routine physical health monitoring including bloods, vital signs and weight; and referrals to specialist services if required. We discussed the Mental Welfare Commission 'Adult acute wards' themed visit report 2017 and the recommendation that services were required to give better attention to physical health care and health promotion. The SCN informed us that the nursing team are continuing to develop physical health care plans and we will see on our next visit how this is progressing.

We discussed liaison between the ward and the Adult Eating Disorder Service (AEDS) which is based at Florence Street Resource Centre. The SCN commented that both services work closely together, and that the inpatient service received input and assistance with assessment, care planning and treatment from the specialist service. This collaborative approach is evidenced in the patient file.

There was comprehensive evidence of clinical psychology assessment and treatment plans, and the provision of individual supportive psychotherapy. We were informed last year that the senior staff were being trained in mentalisation-based therapy and the plan was for this training to be cascaded to all staff. We were pleased to hear that all the staff within the service have been trained in this therapy and also that the psychology department provide weekly supervision to the staff team.

We were informed that there were plans to commence a fortnightly reflective practice group for the staff team which may include: the importance of sustaining safe practice, help to continually improve the ward environment, self-evaluation and reorientation and re-evaluating experiences.

Multidisciplinary meetings (MDT) are held on a weekly basis. Patients are encouraged to attend, as well as carers and families when appropriate. The clinical discussions that occur during those meetings are well documented and generate a clear action plan within treatment goals. Within the MDT meeting there is evidence of input from specialist services, including occupational therapy, physiotherapy, dietetics, psychology and pharmacy. We were advised that pharmacy input is also regularly available and the pharmacist reviews the patient prescription sheets on a regular basis.

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 in the patients' notes. The Greater Glasgow and Clyde care plan documentation sheet for information on legislation was accurate and reflected the patients' current legal status.

We examined drug prescription sheet and treatment certificates (T2/T3) which were in place for all the patients who required them. MHA paperwork and copies of all relevant documentation were within the patients' files as appropriate.

Rights and restrictions

The SCN advised us of the recent development within the service of 'the patient conversation'. This process gathers information from the service users regarding their experience of the service. The information helps staff to consider and evaluate care and treatment from the service user's perspective, and as a result continually allows the service to improve the planning and delivery of services. We look forward to seeing evidence of this development on our next visit to the service.

Patients we spoke to were aware of their right to access advocacy. There was information available on the wards with contact details of the advocacy service. We met with an advocacy worker who informed us of the service and that they visit the ward on a weekly basis offering a drop-in service and one-to-one appointments.

On the day of our visit, three patients were on an enhanced level of observation. Patients with an eating disorder also require special observation and supervision to support them before and after mealtimes and snacks. Staff adhere to current national guidelines on the use of observations. Within the patient file, we saw evidence of regular reviews and updated risk assessments. This ensured that patients received care in the least restrictive way possible.

Activity and occupation

When we spoke to the patients and reviewed their notes, there was good evidence of a range of different activities that were on offer. The recovery model is used to underpin activities in the ward. We note that patients had access to breakfast, snack and lunch groups; relaxation, art and crafts, quizzes, baking, newspapers and discussion groups. The occupational therapists based in the unit also provided a range of other services including functional assessments, recovery-focussed group work and one-to-one sessions.

We were informed of plans to extend the provision of activities in the evenings and at weekends. The service has recently employed three Band 5 therapeutic activity nurses (TANs) and three Band 3. This development is to support the provision of activities in the evening and at weekends for patients.

Some of the patients with whom we met, who were being treated for an eating disorder, commented that there was a lack of suitable activities for them to attend. Some activities are restricted due to the individual presentation of each patient. The TANs have been trained in the treatment and support of patients who have an eating disorder. They have commenced some one-to-one activities to assist with this issue.

The physical environment

We were pleased to see that the ward was clean, bright and well maintained. The staff commented on an ongoing issue with the environment in that the heating system is difficult to regulate, leading to the ward becoming overheated in the summer and cold in the winter months. The ward has an activity room, one main seating area and a female seating room.

One of our previous recommendations was regarding 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 plan and close to the road. For reasons of safety, staff state that it is difficult to leave the ward door open for patients to freely access the garden area. A garden gate would help to define the space and make it more accessible whilst ensuring safety.

Recommendation 1

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

We wish to draw your attention to this recommendation as it was made at our previous visit and it appears no action has been taken.

Summary of recommendations

1. Hospital 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 this recommendation 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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