

**Mental Welfare Commission for Scotland**

**Report on an announced visit to:**

Ward 3, Parkhead Hospital, 81 Salamanca Street, Glasgow G31  
5ES

**Date of visit:** 12 October 2017

## **Where we visited**

Ward 3 is a 20-bedded adult acute mixed sex ward. The ward is situated within Parkhead Hospital. 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 the time we made recommendation about; care planning, named nurse system, patient activity and the environment.

On the day of 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.

We were pleased to hear that plans to move Wards 1 and 3 (Parkhead Hospital) to the Stobhill Campus into a refurbished ward is now being progressed. Planning and preparation for the move has commenced. Families and patients have been concerned about the availability of public transport to Stobhill Hospital. Senior management are meeting with the bus companies to attempt to resolve this issue.

## **Who we met with**

We met with and reviewed the care and treatment of eight patients and met with two family members.

We spoke with the lead nurse for the service, senior charge nurse, medical and nursing staff.

## **Commission visitors**

Mary Leroy, Nursing Officer

Mary Hattie, Nursing Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

There was a calm atmosphere in the ward. The patients we spoke to were positive about the care and treatment provided by the nursing staff and allied health professionals, and had no concerns to raise. Two of the patients commented on the excellent leadership within the ward, "the senior charge nurse (SCN) will always make time to meet with you". Staff were knowledgeable about the patients when we discussed their care.

We found excellent medical assessment and five areas assessments by the nursing staff. Care plans were person centred and detailed in terms of physical and mental health. There was also evidence that patients' strengths and abilities were reflected

within the care plans. Those plans promoted patient participation and were recovery focussed. The care plans were well evaluated and reviewed.

Risk assessment and safety plans gave a clear history of risk, identified triggers and coping strategies were documented in the supporting action plan. The risk assessment and safety plan were reviewed on a regular basis: this was either on a daily basis, or weekly by the key nurse and also through the multi-disciplinary team (MDT) meeting.

There are five consultants on the ward, most of the meetings occur on Monday and Tuesday. 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. The clinical discussion that occurs within the meeting is well documented and it generates a clear action plan with treatment goals. There was patient involvement in the MDT meeting and in the compilation of care plans. Entries within the chronological notes were generally to a good standard. The notes evidenced a MDT approach to care with contributions from medical staff, nursing staff and allied health professionals.

The relatives we spoke with were positive about the care and treatment provided by the nursing staff. Staff informed us there was regular contact with families and carers, telephone calls and conversations with families and relatives documented in the patients' files.

We were informed there is psychology input into the ward. The SCN commented on the specific value of this service in relation to patients who present with complex care needs.

The service have trained the majority of the staff in mentalisation based therapy (MBT), this approach underpins clinical understanding, the therapeutic relationship and therapeutic change.

We were advised that pharmacy input is also regularly available and the pharmacist reviews the patient prescription sheets on a regular basis.

There was 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.

### **Use of mental health and incapacity legislation**

The copies of the certificates authorising detention under the Mental Health Act (MHA) were in the patients' notes. The Greater Glasgow and Clyde care plan documentation sheet for information on legislation was accurate and reflected the patient's current legal status.

We examined drug prescription sheet and treatment certificates (T2/3), which were in place for all patients who required them. They were filed with the patient's medication chart, enabling easy checking and reference to be made.

Adults with Incapacity Act (AWI) s47 consent to treatment authorisations were in order along with accompanying care plans.

## **Rights and restrictions**

On the day of our visit one patient was on enhanced 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.

We discussed advocacy services and noted that many of the patients had access to advocacy. There were advocacy leaflets visible within the ward setting. The staff remark that they have good links with the advocacy service, referrals are responded to quickly and the service is delivered on a one-to-one basis.

During interview with the patients we met, they were aware of their legal status and their rights. One of the patients informed us of their 'advance statement'. An advance statement is written by someone who had been mentally unwell. It sets out the care and treatment they would like if they become ill again in the future.

## **Activity and occupation**

We were able to talk to patients about the activities on the ward they had participated in. Patients were generally positive about the activities and groups on offer and able to discuss the activities they participated in and enjoyed. The daily activity programme was displayed prominently in the ward. We found documented in the chronological notes participation in one-to-one sessions and group work. The staff also documented when the patient did not want to participate in an activity.

The ward activities are facilitated by occupational therapists (OT) and therapeutic activity nurses (TAN). We found a good range of activities; skill building, physical exercise, relaxation and art and craft. We also note that therapeutic one-to-one work with patients is offered, this is dependent on patient need. The therapeutic interventions are anxiety management, relapse management, managing low mood and psychosis and education.

Within the patients' files we found good evidence of comprehensive OT assessments and reports.

At weekend activities are led by the ward staff. The provision of activities can be affected by clinical need, if the wards is very busy it is difficult for the nurses to deliver ward based activities.

## **The physical environment**

As mentioned earlier in this report we are pleased to report that the service is planning to move in February 2018 to a refurbished ward on the Stobhill Campus.

The ward was clean but the paintwork was tired. We were informed that any issues regarding the need for repairs were responded to quickly by the maintenance service.

The ward has six single rooms with en-suite facilities and a three-bedded bay area. The bay bedrooms look dated in comparison with accommodation available in new acute psychiatry wards.

The ward has three seating areas and a dining room. The garden is accessed by stairs and a lift. The gardens are semi enclosed, pleasant and well stocked with plants. We were informed that many patients participate and enjoy the gardening group.

### **Service response to recommendations**

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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