

Mental Welfare Commission for Scotland

Report on unannounced visit to: Ailsa Ward, Stobhill Hospital,
133 Balornock Road, Glasgow, G21 3UW

Date of visit: 24 October 2016

Where we visited

Ailsa ward is a 20-bedded rehabilitation unit, principally serving the north-east of Glasgow. On the day of our visit there were 18 patients in the ward.

The ward was opened in March 2015 and replaced the Orchards on the old Ruchhill Hospital site. The ward has a complex mix of patients. Many of the patients have been in hospital for a number of years. Motivation is an issue because of their illness, and getting engagement in the rehabilitation process can be challenging. Some patients were quite unwell; others have considerable physical health needs. Additionally, there are still some patients who have continuing care needs and do not fulfil the ward's brief and it will take some time to find alternative placements for them.

Who we met with

We met with and/or reviewed the care and treatment of 10 patients and spoke to a number of the nursing staff.

Commission visitors

Alison Goodwin, Social Work Officer

Mary Leroy, Nursing Officer

Jamie Aarons, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We met with 10 patients and reviewed their records. The patients we spoke to did not raise any concerns about the ward and were very positive, bar one, about their interactions with nursing staff, occupational therapy (OT) staff, psychiatry and psychology. It was clear from the chronological notes and from patients themselves that there was one to one time with their named nurse and nurses generally spent a lot of time with patients.

Independence in personal care, meal planning, shopping, laundry and tidying of bedrooms are an integral part of the rehabilitation programme. Some patients understood their rehabilitation programmes and were largely engaged with these, others require considerable prompting, support and encouragement from staff, depending on the complexity of their needs and motivation. The patients we spoke to varied greatly in their ability to participate in these areas.

Care plans were very person-centred and detailed in terms of people's mental and physical health needs. They included some aspects of daily living skills that were being worked on, particularly personal care. Others areas were covered in the OT assessments and plans.

For those who were in the process of moving on, there were detailed discharge plans which were very personalised, were clear on the areas that the patient was working on and took into account the patient's views and anxieties.

The rehabilitation service comprises Phoenix House (an 8 bedded community-based unit) and Ailsa ward. We were pleased to hear how closely the units work together. There is a single referral form and these are discussed at a monthly meeting between the two units to ensure the most appropriate placement for the individual. The same consultant psychiatrist covers both units and staff reported positively on how available he was to them. There is a full-time (FT) clinical psychologist dedicated to the two units and nursing staff reported the benefits of her guidance in how they can best support patients as well as her direct input with patients. There is a FT occupational therapist covering the two units as well as a full time OT assistant for Ailsa. Both units use the SARA (supported accommodation resource allocation) system to access accommodation vacancies in Glasgow City.

We were told that there was good support by referral from speech and language therapy, dietetics, physiotherapy and chiropody. The GP service is from Springburn Medical Centre, who attend the ward three times a week. Many of the patients have complex physical health issues and we saw evidence of good physical health care input in the chronological notes and in the care plans. There are annual physical health checks and a robust reminder system for these.

There is good attendance of the multidisciplinary team (MDT) members at the weekly ward meetings and it is clear from the chronological notes and MDT minutes that there is good communication and team work. There is a rolling programme of detailed review for patients. However if there are any immediate issues for any patient, these are also discussed at the MDT meeting. There was good documentation of the MDT meetings and the more detailed reviews.

Patients attend the MDT meetings and are involved in setting the goals for their rehabilitation. Relatives are also invited to attend where relevant.

Use of mental health and incapacity legislation

We were pleased to find all consent to treatment certificates (T2) and certificates authorising treatment (T3) forms under the Mental Health (Care & Treatment) Act 2003 (MHA) were in place.

There were good personal spending plans for those patients whose funds were managed under Part 4 of the Adults with Incapacity (Scotland) Act 2000 Act (AWI).

There were copies of s47 certificates of incapacity to consent to medical treatment under Part 5 of the AWI Act, where appropriate.

Rights and restrictions

There is an open door policy. Patients have varying arrangements for time spent off the ward. These are clearly written and therefore easily accessible on a large board in the nursing station. The board also provides information on the patient's status under the MHA and AWI Act, the next date for MDT review, and date for their annual health check.

Bedroom doors are locked during the day but are accessible at any time if patients ask staff. This is due to the loss of belongings. None of the patients we spoke to expressed any concern about this but the need for it should be kept under review.

Activity and occupation

Occupational therapy staff have a programme of activities to develop daily living skills including breakfast and lunch groups, shopping and menu planning. They also organise community outings as do nursing staff. The ward has its own car which is particularly useful for those with poor physical health, though we were told the choice of vehicle is not ideal for some. There are also art and exercise groups and there was an information technology (IT) group on the day of our visit. Some patients have been involved in tending the ward garden over the summer, assisted by one of the nurses.

There is a variety of recreational activities. There is a pool room on the ward and various games and DVDs. Staff organise birthday celebrations, parties and various trips for coffee, bowling or the cinema. There is a community meeting for patients and staff have been responding to suggestions from patients about activities. However sometimes lack of motivation from patients means the arrangements fall through when they have been set up.

Patients do not have an individualised weekly activity planner, so it is hard to see how their week is structured. We understand that activities for some patients are necessarily opportunistic depending on their mental health and motivation on the day. However, it may be useful to consider a weekly activity planner for some patients so it is more evident when and what individuals are doing and perhaps lead to more discussion with the individual about the expectation of participation in the programme.

We saw therapeutic work with individuals on a one to one basis from psychology and some nursing staff. The senior nursing staff had had some training in mentalisation in relation to the needs of one particular patient. Whilst recognising the diverse needs of the patients, we considered there was scope to develop more therapeutic recovery-focussed groups in the ward, such as symptom management, coping strategies, problem-solving groups.

Recommendation 1:

The service should consider, where relevant, the use of individual activity planners, which would include all the therapeutic, educational, social and recreational activities that are contributing to the patient rehabilitation programme, so there is clarity for the patient and for staff.

Recommendation 2:

The service should review the activities available to patients to include more therapeutic recovery-based groups.

The physical environment

The unit is bright, clean and spacious with a lot of natural light. It is nicely furnished and has a variety of sitting areas, a pleasant dining room, a games room, an activity room and a training kitchen. There are great views from the ward to the Campsie Hills.

The ward has 12 individual spacious bedrooms with en-suite facilities and two 4-bedded dormitory areas with two wet rooms in each. All areas are wheelchair accessible. Some rooms and bed areas were more personalised than others, though this appeared to be through patient choice. We welcomed the purchase of duvets to replace the blankets as several patients said their bedroom was sometimes not warm, particularly in the winter.

We were impressed with the layout, flowers and upkeep of the enclosed garden to the rear of the ward. We heard that some patients had grown vegetables over the summer as well as looking after the flower beds. It was a valuable facility for all the patients to sit in and relax and seemed to be well used.

Summary of recommendations

1. The service should consider where relevant the use of individual activity planners, which would include all the therapeutic, educational, social and recreational activities that are contributing to the patient rehabilitation programme so there is clarity for the patient and for staff.
2. The service should review the activities available to patients to include more therapeutic recovery-based groups.

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.

Alison Thomson
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 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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