Mental Welfare Commission for Scotland

Report on an announced visit to: Isla and Jura wards, Stobhill Hospital**,** Balornock Road, Glasgow G21 3UW

Date of visit: 5 April 2018

Where we visited

Isla and Jura wards provide assessment and treatment for older men and women. Isla has 24 beds and provides care for older adults with a mental illness, Jura has been reduced to 20 beds since our last visit and provides care for people with dementia.

We last visited this service on 4 August 2016 and 13 November 2015 respectively and made recommendations relating to care plans, activities, confidentiality and garden access.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act). This is because we have a statutory duty to monitor this.

Who we met with

We met with and/or reviewed the care and treatment of 14 patients and met with two carers/relatives/friends.

We spoke with the service manager, the senior charge nurse and members of the nursing team.

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

Moira Healy, Social Work Officer

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Both wards have input from four consultant psychiatrists. There is regular input from occupational therapy (OT). There is regular psychology input; an open meeting is held in Jura ward weekly, attended by staff from both wards. Staff can discuss complex cases and make referrals at these meetings. Other allied health professionals are available on a referral basis.

Multi-disciplinary team meetings (MDTs) are held weekly. Decisions were recorded clearly with documented evidence of good communication and consultation with families and carers, who are encouraged to attend reviews. This was also commented on positively by the relatives we spoke with.

Risk assessments are reviewed regularly. Care plans are reviewed and this is documented within the chronological notes, however the care plans are not updated to reflect changes.

Care plans for stress and distress were in place for a number of patients whose files we looked at. In Isla ward we identified patients who were clearly experiencing stress and distress who did not have care plans to address this. In the majority of cases, where these were in place, we found generic phrases such as 'use de-escalation techniques', with no detail about what these are for the individual.

Staff are trained in the use of the Newcastle model for managing stress and distress, and there were some excellent assessments using this framework. There were clear, detailed chronological notes of care, which indicated that staff were providing person-centred management of distress. However, the information gathered had not been incorporated into the care plan to ensure a consistent approach.

We found detailed assessment and care planning for physical health care needs.

Recommendation 1:

Managers should ensure that care plans for the management of stress and distress are in place as required and the information gathered within the Newcastle assessment tool is incorporated.

Use of mental health and incapacity legislation

Where patients were detained under the 2003 Act, copies of the detention paperwork was available as required. Treatment certificates, T3s and T2s, were in place to cover treatment under part 16 of the Act.

We brought one treatment certificate to the attention of staff for immediate review as it was not clear if the patient was capable of consenting.

In relation to the Adults with Incapacity (Scotland) Act 2000, in Jura Ward there was clear information about whether there was a guardian or power of attorney in place and in the majority of cases copies of the powers were available. Where these were not in place, staff were actively requesting that they be provided. Within Isla Ward there was a lack of clarity around whether there were proxy decision makers in place and who these were.

One patient was profoundly deaf and used British Sign Language as their primary means of communication. It was clear from the notes that staff used other methods such as writing things down for them, but there was no consistent approach across the team and there was no communication care plan in place. Interpreters were provided for particular events such as review meetings and mental health officer visits.

Recommendation 2:

Managers should ensure that, where a patient has particular communication need, these are addressed within a care plan to ensure there is a consistency of approach taken and adequate input from an interpreter provided.

Recommendation 3:

Managers should ensure a regular audit of the accuracy of the information around proxy decision makers within Isla Ward is carried out.

Rights and restrictions

Both wards have locked doors and keypad entry systems. There is a locked door policy and information on how to leave the ward is displayed beside the exit.

Activity and occupation

Both wards have input from OT services, however this input is limited, with less than two full-time qualified OTs and two technicians covering three wards. In Jura Ward the OTs provide a number of group activities such as the music group, however in Isla Ward we were told the majority of OT time is taken up with functional assessments.

Currently Isla Ward benefits from having an on-site therapy kitchen. This facility will be lost shortly to provide additional laundry facilities to accommodate the increase in adult acute bed numbers on site. As a result, patients will need to go to the kitchen in the adult acute unit if they are to participate in assessment or therapy sessions. As this is some distance away, up a steep hill, this will restrict access to the facility. We are concerned that this may disadvantage some patients and ask that mangers keep us informed of arrangements in place to mitigate the impact of this change.

We found completed activity records in most of the files we looked at. Whilst both wards benefit from therapet and music in hospitals visits, the activity provision is limited as neither ward has a dedicated patient activity co-ordinator. There is a need for a more focussed approach to the provision of a range of therapeutic and recreational activities to meet individual needs and provide a meaningful day.

Recommendation 4:

Management should consider providing a dedicated activity co-ordinator to ensure that patients have access to a range of activities to meet their needs.

The physical environment

Both wards were bright, spacious, clean and in good decorative order. They both had well-designed secure garden facilities which we were advised are well used by patients and relatives when the weather allows.

There are a number of small quiet spaces, as well as two large sitting rooms in each ward; there are murals in these areas depicting a variety of memorabilia relating to the Glasgow area. The memory walls in both wards are also an interesting feature, the

local museums department maintains some of the displays and these are changed periodically.

Beds are within a variety of single, double and four bed dormitory areas. All have en-suite shower facilities. Unfortunately, these are fixed head showers which are not suitable for showering patients who require assistance from staff to maintain their personal hygiene.

Recommendation 5:

Managers should review the fixed shower heads with a view to replacing them with alternative fixings.

Any other comments

Both wards have recently undertaken a review and feedback form, this has been very positive with relatives commenting on feeling very welcome. There were positive comments about staff communication and availability and feeling involved in care decisions. The wards had a very calm and welcoming atmosphere, staff were visible within the ward areas and were interacting with patients. The ward team are clearly enthusiastic about providing high quality care.

Summary of recommendations

1. Managers should ensure that care plans for the management of stress and distress are in place as required and incorporate the information gathered within the Newcastle assessment tool.

2. Managers should ensure that, where a patient has particular communication needs, these are addressed within a care plan to ensure there is consistency of approach and adequate input from an interpreter.

3. Managers should ensure regular audit of the accuracy of the information around proxy decision makers within Isla Ward.

4. Managers should consider providing a dedicated activity co-ordinator to ensure that patients have access to a range of activities to meet their needs.

5. Managers should review the fixed shower heads with a view to replacing them with alternative fixings.

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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