

**Mental Welfare Commission for Scotland**

**Report on an announced visit to:**

Stobhill Hospital, McKinnon House, Struan Ward, 133 Balornock Road, Glasgow G21 3UW

**Date of visit:** 26 July 2017

## **Where we visited**

Struan Ward is a 20-bedded acute mixed sex ward. The ward has six single rooms with three bay areas: two female (four beds) and one male (six beds). We last visited this service in July 2016 as part of the Commission's national themed visit to acute wards in Scotland. We last visited this service in March 2014. At the time we made recommendations about mental health legislation paperwork being up to date, methods of recording and storage, and specified person legislation.

On the day of this visit we wanted to follow up on the previous recommendations and look at care planning documentation and practice to ensure it is recovery focussed. We also wanted to look at the physical health and activities of the patients.

The areas identified above that we have focused on are themes identified from our adult acute themed visit report as areas that the services need to improve.

## **Who we met with**

We met with and/or reviewed the care and treatment of eight patients.

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

## **Commission visitors**

Mary Leroy, Nursing Officer (visit co-ordinator)

Juliet Brock, Medical Officer

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

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

All interactions with patients we observed were friendly and supportive. The patients we met with spoke positively about their care and treatment. One person commented that the "the doctors and the nurses looks after me in here". Some patients said that "the nurses can be busy, but they will always make time to talk to you". The patients said they have regular contact with their responsible medical officer (RMO).

Some of the care plans were person centred and recognised the individual's strengths and needs. A number of the care plans we reviewed varied in quality and often lacked individualised content. The care plans identified needs and goals, however the method of how the goals could be achieved was not always present. On speaking with the nursing staff the information was often known, but details not recorded in writing. This is an area for improvement.

Care plans need to be recovery focussed and person centred and promote patient participation. Through discussion with the staff, we note that there were some patients with a diagnosis of borderline personality disorder being admitted to the service. We discussed the treatment philosophy of the unit for this patient group, who often present with complex care needs. There were some care plans to support the complexity of this patient group but they lacked detail, e.g. “to use coping strategies”, with no further information on what strategies were helpful for the patient.

The care plans were evaluated and reviewed and this information was recorded in the patients’ files.

**Recommendation 1:**

Managers should ensure nursing care plans are person centred, and contain individualised information reflecting the care needs of each person and identifying clear interventions and care goals.

Risk assessments and supporting care plans were reviewed on a regular basis. This occurred either on a daily basis by the key nurse or through the weekly multidisciplinary team (MDT) meetings.

There was evidence of patient involvement in the MDT meetings. Entries within the chronological notes were generally of a good standard. The notes evidenced a multi professional approach to care. There is an MDT meeting once a week, we were informed that most of the patients attend this meeting. The clinical discussions that occur within the meeting are well documented and generated a clear action plan with treatment goals.

The consultants for the ward have frequent contact with the patients. We were informed that as well as the weekly MDT meeting there is also another format of a weekly patient review which is for any other issues that arise.

There is now regular input from psychology, who provide one to one interventions to meet patient’s specific needs. The nurse in charge informed us of plans to refer complex patients for psychological formulation to assist with the patient’s difficulties and seek a multi-professional approach to guide care planning and intervention.

The pharmacist attends the ward on a weekly basis to review medical prescribing and attends the MDT meeting on a weekly basis. Within the patient files we evidenced medication reviews addressing practical medicine optimisation and medicine adherence issues thereby improving clinical effectiveness of medication taken by patients.

We saw good attention to physical healthcare needs, a full medical/physical assessment on admission, with regular physical health check monitoring, and referral to specialist services if required.

The staff informed us that they have good links with advocacy services and that referrals are responded to quickly. The service meets with the patients on an individual basis. We heard from patients that there was good advocacy input into the ward and this was confirmed in file reviews.

The ward informed us that they have implemented the 'triangle of care standards'. This is applied in practice by ensuring that the family know and have contact with the patient's named nurse. Within the patient's notes there was evidence of frequent communication with families. We discussed the MDT meeting and were informed that the families were being invited to this meeting, but that the service was operating and promoting a model where the consultants were offering one to one meetings with patients and families. The nurse in charge commented that due to time pressure during MDT meetings that this format was working well.

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

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

We examined drug prescription sheet and treatment certificates (T2/3): consent to treatment certificates were filed with the patients medication chart enabling easy checking and reference to be made. The RMO must ensure that prescriptions of medications for detained persons are properly authorised, with a T2 or T3 form in place where this is required by law. We identified some issues with documentation regarding medical treatment. They were brought to the attention of the nurse in charge so they could be remedied as quickly as possible.

#### **Recommendation 2:**

Managers should ensure a system should be implemented and audited to ensure that the correct paperwork (T2 and T3 form) is in place and accessible.

We were unable to locate on file a patient's Adults with Incapacity Act section 47 certificate for a patient who lacked capacity to consent to physical care and treatment. This was discussed with the nurse in charge on the day, and an audit of all section 47 certificates will be completed to ensure that they are in date and include relevant treatment plans, and are filed in a consistent place to ensure that staff are aware of its existence the patients file.

#### **Recommendation 3:**

Managers should ensure that treatment plans associated with s47 certificates are held with the medication prescription sheet to ensure that treatment is legally authorised.

## **Rights and restrictions**

On the day of our visit three patients were on enhanced observations, with one of the patients on two to one observations. Staff adhered to national guidelines on the use of observations. Within the file we saw evidence of regular reviews and updated risk assessments. This ensures that patients received care in the least restrictive way possible.

The staff informed us that there is a policy in place for restricting entry/exit. We were given access to the policy for locking doors on open wards for Greater Glasgow and Clyde (intranet version). We were informed by staff that the door is only locked after very careful considerations of individual service users need. We also saw on the day that the policy did not prevent other patients from entering and leaving the ward.

## **Activity and occupation**

We were able to talk to patients about the activities on the ward that they had participated in, however there was little evidence in the chronological notes on the activities patients were attending. Two of the patients we interviewed comments on there being “very little structured activity” and said they passed the day “watching television and sleeping”. Other patients commented on having attended relaxation and arts and craft groups. There is an occupational therapy unit that inputs into the ward, providing a range of services including functional assessments, individual sessions, and preparation for discharge.

The occupational therapy (OT) offer group work to all the wards within McKinnon House: breakfast/ lunch/snack group, tenpin bowling, relaxation, quiz, art and crafts baking and newspaper and discussions groups.

The nursing staff within the wards arrange some activities in the evening and at the weekends. The nurse in charge on the day informed us that the provision of activities for the patients is often impacted on by what is happening on the ward. If the ward is clinically demanding, it is difficult for nurses to deliver ward activities.

## **Recommendation 4:**

Managers should ensure there is an adequate provision of activities in the evening and at weekends.

## **The physical environment**

The ward was clean, bright and well maintained. The staff commented on ongoing issue with the environment in that the heating system is difficult to regulate, leading to it 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.

## **Any other comments**

The nurse in charge on the day discussed that there had been some recent issues with staffing shortages and long term sickness, and two newly employed staff members had left the service within a short period of employment resulting in concerns regarding staff retention. Having to rely on agency staff who may not be so familiar with the ward and patients. There were concerns about the impact this can have on the delivery of care.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should ensure nursing care plans are person centred, and contain individualised information reflecting the care needs of each person and identifying clear interventions and care goals.

### **Recommendation 2:**

Managers should ensure a system should be implemented and audited to ensure that the correct paperwork (T2 and T3 form) is in place and accessible for patients subject to compulsory treatment.

### **Recommendation 3:**

Managers should ensure that treatment plans associated with s47 certificates are held with the medication prescription sheet to ensure that treatment is legally authorised.

### **Recommendation 4:**

Managers should ensure there is an adequate provision of activities in the evening and at weekends.

## **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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