Mental Welfare Commission for Scotland

Report on announced visit to:

Parkside North and Parkside South Wards, Cleland Hospital, Bellside Road, Cleland, ML1 5NR

Date of visit: 31 August 2023

Where we visited

Parkside North Ward is a 15-bedded all-male ward and Parkside South Ward is a 15-bedded all-female ward. The age range of the patient group is from mid-50s to mid-80s. Most of the patients have long standing mental illness and complex care needs; some have spent the majority of their adult life in care settings. For many, attempts to offer care in the community or residential care homes have been unsuccessful.

At the time of our visit, there were 11 patients in Parkside North and 12 patients in Parkside South. The wards now have five and four beds respectively, used by the rehabilitation and recovery services, with a focus towards community discharge. The wards offer a recovery-focussed rehabilitation model of care.

We last visited this service in June 2021 and made a recommendation for the Wi-Fi issues in the unit to be upgraded. This has now been resolved and we were informed that the Commission recommendation was key to having this upgrade happen so promptly.

Who we met with

We spoke with one patient, reviewed the care and treatment of six people, and spoke with one relative.

We spoke with the senior charge nurses for both wards, the senior nurse and various nursing staff. We also spoke with the clinical psychologist and the physiotherapy assistant.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support, and participation

Prior to, and during our visit we were impressed at the range of skills competently demonstrated by staff; this was particularly evident in discussions with the senior charge nurses, where their commitment to their staff team and the compassion held for their patients was commendable. We acknowledged this with the senior nursing team when we fed back at the end of the visit, and we were advised that it was a "team effort" with all staff in the wards.

We spoke with a relative of one of the people who had been in Parkside South for two years. They were very complimentary of the nursing team saying, "they do everything possible". They also commented that the consultant psychiatrist was "absolutely wonderful" and couldn't praise them highly enough, and that "they make every effort to keep me up-to-date".

We were unable to get direct feedback from the patients as they declined to speak with the Commission visitors, which may have in part, been as a result of the cognitive frailty and mental health of patients.

Care and treatment

Since our last visit a new electronic recording system has been introduced, Morse, which we found easy to use. Information on patients' care and treatment was held in two ways; Morse, and a paper light file that contained legal paperwork such as Mental Health Act records for the patient and other information for quick reference, such as contact details and information on the GP, community psychiatric nurse etc. All the information contained in the paper files was available on Morse. We did note for some individual patient records, the information that was held in the paper files had not been transferred on to Morse. We would like to see standardisation of what is recorded on Morse and what was held in the paper files. In the paper files, we saw each patient had a "My Story So Far" or in some cases had a "What Matters to Me", on file.

Recommendation 1:
Managers should ensure that patient information is replicated in the electronic record, Morse, and the paper light files.

Care plans were detailed and person-centred, and addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual; this is what we found in our previous visit. We saw regular reviews of the care plans and we also found that the care plans evidenced patient involvement. Daily notes were also detailed, person-centred, and recorded in a timely manner.

Occupational therapy notes were person-centred and there was clear evidence of supporting patients with activities of daily living, where they were able to participate. Throughout the notes we found good family involvement recorded, particularly where there was a legal proxy decision maker, such as a welfare guardian or power of attorney, in place. Patients were actively involved in care planning, and we noted that there was a place to record the patient's satisfaction of the service. We found a good deal of information contained in the one-to-one discussions that individuals had with their named nurse. We noted the use of the Care of the

Elderly Frailty Scoring where it was appropriate, and comprehensive risk assessments that were detailed, using the traffic light template.

We found that physical health care needs were being addressed and followed up appropriately and there was input from the local GP service, who visited once each week. There was also evidence of input from advanced nurse practitioners (ANPs) as required.

Multi-disciplinary teams (MDT)

The multi-disciplinary teams consisted of consultant psychiatrists, nursing staff, psychology, a rehabilitation speciality doctor, visiting GP, physiotherapy, and occupational therapy staff. Not all attended the MDT meeting that was held on a weekly basis, although they were available for advice, as needed. The MDT meeting notes were concise, detailed, and reflected the patient's progress on a weekly basis. They evidenced the patient's current situation and supported the ongoing decisions made by the MDT. All MDT notes were recorded on Morse using the MDT template.

Where the patient was able to attend the MDT, they were be invited to do so. Family members or carers were also invited to the meetings. If they were unable to attend, the nursing teams provided an update for the families or carers.

The wards were supported by a local GP practice for physical health care checks and there was a consultant psychiatry who provided input for mental health care. There was a full-time occupational therapist who covered all patients in Cleland Hospital. All other allied health professionals were accessed via referral.

Use of mental health and incapacity legislation

On the day of our visit, 15 of the 23 patients in the two wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Where there was a proxy decision maker, either welfare guardian or power of attorney, we found this had been documented in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. There was one patient that required treatment under the AWI Act who had two s47 certificates on file, one was incomplete and the other had no care plan recorded. We raised this with the nurse-in-charge and were advised that this would be updated as a matter of urgency.

For patients who had covert medication in place, all appropriate documentation was in order, including the pathway where covert medication was considered appropriate. We advised staff that covert medication pathways should be regularly audited.

The Commission has produced good practice guidance on the use of covert medication at: https://www.mwcscot.org.uk/node/492

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, however, they did not correspond to the medication being prescribed. We brought this to the attention of the senior nurses on the day for urgent action.

Recommendation 2:
Managers should ensure medication records are reviewed for patients requiring forms T2 and T3 authorising treatment under the Mental Health Act and ensure s47 certificates are completed appropriately.

Rights and restrictions

The main doors to the units are key card entry. The main ward doors are usually locked for the safety and security of the patients in the wards. Staff were available to allow entry and exit to visitors, as required. There is also a reception at the entrance to the wards who would assist visitors with entry as appropriate.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at: https://www.mwcscot.org.uk/law-and-rights/rights-mind.

Activity and occupation

We heard that staff try hard to ensure that patients are active during the day. For individual patients with a learning disability, there were tailored plans that individualised activity. We heard that there had been a recent outing to a local garden centre with the rehabilitation occupational therapist. There were no limits to freedom in the ward areas, and patients were able to move around without restriction.

The physical environment

There is an assessment kitchen for patients to use and to allow occupational therapy assessments to take place on site. There is also a large communal area which is used for group activities and family visits, when required. All bedrooms are single with en-suite toilet facilities.

The wards had a homely feel, with good personalisation in rooms, as far as it was possible to do so. We noted that where a patient needed additional space, this was accommodated on the ward. There is a high standard of cleanliness and domestic staff were included as part of the ward team. The large communal area off the wards was pleasant and provided an area for social occasions, group work, and family visits for all patients. The garden area was pleasant for patients and visitors to sit in during good weather.

Summary of recommendations

Recommendation 1:
Managers should ensure that patient information is replicated in the electronic record, MORSE, and the paper light files.

Recommendation 2:
Managers should ensure medication records are reviewed for patients requiring forms T2 and T3 authorising treatment under the Mental Health Act and ensure s47 certificates are completed appropriately.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
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 Commission 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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