Mental Welfare Commission for Scotland

Report on announced visit to:
Stobhill Hospital, Appin Ward, Balornock Rd, Glasgow G21 3UW

Date of visit: 4 November 2024

Where we visited

Appin Ward is a 20-bedded unit that provides care for older adults who have complex mental health care needs and covers the area of Glasgow City. The number of individuals that can be admitted to the ward is currently capped at 15, due to staffing issues. Recruitment is underway to enable the ward to open once again to full capacity.

On the day of our visit, there were 13 people on the ward. Four people who were there no longer required inpatient care and their discharge from hospital was considered to be delayed. We heard that there had previously been delays in allocating social workers in Glasgow City Council and this had contributed to the delay in discharging people who were waiting for guardianships orders to be granted. We heard that this had improved since the fortnightly delayed discharge meetings had been established, which were attended by senior staff from health and social work.

We last visited this service in March 2022 on an announced visit and made recommendations on care planning, record keeping and ligature risk. The response we received from the service indicated that all the recommendations had been addressed.

On the day of this visit, we wanted to follow up on the previous recommendations.

Who we met with

We met with, and reviewed the care of six people, all of whom we met with in person. We also met with/spoke with three relatives.

We spoke with the senior charge nurse (SCN), the lead nurse and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

What people told us and what we found

We received very positive feedback about the care provided. We heard that staff were caring, understanding and knew the people in their care well. We heard that relatives and patients had the opportunity to attend multidisciplinary team (MDT) reviews, and if they were unable to attend, staff provided feedback.

We heard that relatives felt confident that their loved one was receiving the best possible care. Relatives commented positively on communication and told us that staff were proactive in contacting them if there are any changes or concerns in relation to their relative.

Care, treatment, support, and participation

Care records

MDT reviews, chronological notes, risk assessments and mental health paperwork were held on EMIS. We were told that the ward is progressing towards a complete electronic record, with care plans now being recorded on EMIS.

Care plans were uploaded in the documents file, however once uploaded, care plans cannot be edited to reflect changes in person's presentation; where needs were identified in care plans reviews, a complete new care plan needed to be uploaded every time changes were required. This made it more difficult to view progress made by the individual.

Recommendation 1:
The system for electronic recording of care plans should be reviewed to ensure it is fit for purpose, enabling staff to update care plans to reflect changes identified in reviews to maintain a live document which reflects the patients' progress and supports the delivery of person-centred care.

Care plans addressed the risks identified in the CRAFT risk assessments, which were regularly updated, and where physical health needs had been identified, these were clearly addressed. The level of person-centred detail in care plans varied, with some providing a clear picture of individuals needs and preferences, while others contained statements such as "use de-escalation techniques", without clarifying what those were for the individual concerned.

Recommendation 2:
Managers should ensure nursing care plans are person centred, setting out clearly the interventions and support required for the individual.

We found completed Getting to know me (GTKM) documentation in all the files we reviewed, and this was used to inform care plans. GTKM is a document that collates information on an individual's needs, likes and dislikes, personal preferences and

background, to enable staff to understand what was important to the individual and how best to provide person-centred care while they are in hospital.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Multidisciplinary team (MDT)
There are two consultant psychiatrists attached to the ward and MDT reviews are held fortnightly for each consultant. There are twice weekly GP visits, and access to medical cover from the hospital duty doctor rota. There is dedicated input from psychology, pharmacy, physiotherapy and occupational therapy, and other services such as speech and language therapy, dietetics and palliative care are readily available on a referral basis.

Three monthly MDT reviews are held for all individuals. Each person and their named persons and/or carers, if indicated, are invited to attend these.

MDT decisions were clearly recorded along with who attended and we found evidence of relatives and/or carers being consulted and informed regarding care decisions. We were told that most individuals had an allocated social worker who would attend MDT reviews.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were recorded on EMIS.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required. For one individual we found that the certificate did not authorise all of the medication prescribed; this was raised with the consultant on the day.

Recommendation 3:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this form.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

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 that this was recorded.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the 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.

For those people that were under the AWI Act, we found completed section 47 certificates.

Rights and restrictions

The ward doors were controlled by keypad or push button release. The ward has a locked door policy and has information on how to access/egress the ward displayed beside the doors.

We saw advocacy posters and leaflets available in the ward foyer and we spoke to people who had used this service.

The ward has open visiting arrangements, and where appropriate, people were supported to go out with their visitors, either in the grounds or to the local area.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found that a reasoned opinion was recorded, and the appropriate paperwork was in place. The need for restrictions was reviewed regularly.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statements in the files of the individuals we reviewed.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

The ward has a dedicated therapeutic activity nurse, and there is also a part time occupational therapist and occupational therapy assistants who input to the ward regularly. We saw evidence of regular activities being undertaken on a one-to-one and small group basis, both during our visit and evidenced in the care files we reviewed. This included taking patients outside for walks and shopping trips and regular exercise groups facilitated by the physiotherapist.

The chronological notes contained information on activity participation, outcomes and evidence that individuals' personal activity preferences were being supported and staff were encouraging people to maintain their skills. We also heard from relatives that individuals were supported by nursing staff to go shopping or participate in other activities in the community on a regular basis.

The physical environment

The ward is designed to meet the current safety standards for adult mental health units, and furniture and fittings are designed to reduce ligature risks. The layout of the ward consisted of 20 bedrooms, all of which had en-suite shower rooms.

The ward has a large open plan sitting and dining area which opened onto a courtyard garden. The ward also benefited from an activity room, another small sitting room, a second small courtyard area and an enclosed external garden space as well as a number of sitting areas spaced throughout the building.

The unit was bright, clean, spacious and pleasantly decorated, with artwork depicting local places of interest throughout the corridors. There were raised beds and benches in both the courtyards and the external garden area was well maintained and landscaped with flower beds and garden furniture.

There was a laundry facility for people to use. Staff advised us that there was access to the therapeutic kitchen in MacKinnon House, however they believed that it would be beneficial to have a space in the ward where people could maintain and develop their kitchen skills.

Summary of recommendations

Recommendation 1:
The system for electronic recording of care plans should be reviewed to ensure it is fit for purpose, enabling staff to update care plans to reflect changes identified in reviews to maintain a live document which reflects the patients' progress and supports the delivery of person-centred care.

Recommendation 2:
Managers should ensure nursing care plans are person centred, setting out clearly the interventions and support required for the individual.

Recommendation 3:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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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