Mental Welfare Commission for Scotland

Report on announced visit to:
Stobhill Hospital, Isla and Jura Wards, Balornock Rd. Glasgow G21 3UW

Date of visit: 24 October 2024

Where we visited

Isla Ward is 24-bedded unit for older adults with a functional mental illness. Jura Ward provides assessment and care for older adults with dementia and has 20 beds.

Isla and Jura cover the catchment areas of the northeast of Glasgow and the northeast section of East Dunbartonshire local authority.

On the day of our visit, there were 19 people on Isla ward, five of whom were boarding from adult services, and 16 people on Jura. We were told that patients from adult wards were boarded into Isla on a regular basis due to pressures on adult beds, however the senior charge nurse is involved in transfer decisions and has discretion to refuse inappropriate transfers.

We last visited this service in May 23 and December 22 on an announced visits and made recommendations for both wards on care plan reviews. For Isla Ward we made further recommendations relating to authorisation of medication under the Mental Health (Care and Treatment) (Scotland) Act, 2003 and the unsuitable doors on ensuite bathrooms. The response we received from the service was that the care plan and medication issues were fully addressed, and the replacement of the ensuite doors is under review.

On the day of this visit, we wanted to follow up on the previous recommendations and look at relative involvement.

Who we met with

We met with, and reviewed the care of 13 people, all of whom we met with in person. We also met with six relatives.

We spoke with the senior charge nurses (SCNs), the lead nurse, the physiotherapist, the occupational therapist and several of the nursing staff.

Commission visitors

Mary Hattie, nursing officer

Gemma Maguire, social work officer

Mary Leroy, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

Throughout the visit, we saw kind and caring interactions between staff and patients. Staff were visible and approachable and the staff we spoke with knew the people well.

The relatives and the patients we spoke with were very positive about the care provided and the communication from staff. Relatives told us that "staff treat them like their own family" "Staff always make me feel welcome" "They keep me up to date with how she is doing". One relative told us how important it was for them to remain involved in providing care and how staff had supported them to do this on the ward. Individuals commented "The nurses are very respectful towards me", "they ask me to do things, …I know it is things I need to do, and they are encouraging me".

We heard about the patient flow meeting that involved both inpatient, community team members and care home liaison staff who continued to provide communication and handover planning. Community staff met the individual on the ward where they assessed and discussed what supports would be needed on discharge. One relative told us how reassuring this was for them as they prepared to take their relative home.

Care, treatment, support, and participation

Care records

While multidisciplinary team (MDT) reviews, chronological notes, risk assessments and mental health paperwork have been held on EMIS for some time, up until this summer, AWI paperwork and care plans were paper based. Both wards have recently moved to a full electronic record using EMIS. Care plans are uploaded in the documents file.

We heard from staff that there are difficulties with the system. Once uploaded, care plans cannot be edited to reflect changes in an individual's presentation or needs that have been identified in care plans reviews, therefore a completely new care plan needs to be uploaded every time changes are required. This makes it more difficult to view progress and is cumbersome and time consuming for staff.

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.

In both wards we found detailed CRAFT risk assessments that were regularly reviewed and the identified risks that needed to be addressed in the care plans, which covered both physical and mental health needs. The care plans were

person-centred, detailed and contained all the relevant information that gave a real sense of the individual and their needs.

In Jura Ward, Getting to Know Me (GTKM) documents had been completed for all the individuals we reviewed and the information from GTKM was reflected throughout the individual care plans. GTKM is a document which 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 whilst they are in hospital.

We found excellent person-centred care plans for the management of stress and distress behaviours and where this was an issue for some, we found that this had been noted in the files of those we reviewed; we found that there was use of a traffic light system to identify potential triggers, how distress may present for the individual, and strategies for de-escalation and management. We found recent, meaningful, detailed care plan reviews in the files we looked at.

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)

Both wards have input from four consultant psychiatrists who cover the catchment areas. Isla Ward currently has additional input from a further five consultants who have patients boarded in from adult services.

There is regular input from occupational therapy (OT), psychology, physiotherapy and pharmacy, all who attend the multidisciplinary team (MDT) meetings. We heard that social work referrals are made early in the admission process, however there can be delays in allocation from Glasgow City due to workload pressures.

Input from other professionals including speech and language therapy and dietetics are arranged on a referral basis. Whilst there has been no on-site dietician for the past year, we were told that from 1 November 2024, there will be on-site dietetic support at Stobhill.

We found the MDT meeting notes to be detailed, and they included clear decisions along with any actions that were required and who was responsible for completion of these.

Everyone involved in an individual's care and treatment was invited to attend the meetings, this included patients and families, who could attend in person. If relatives

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

or patients did not attend arrangements were made to feedback to them and this was documented.

Use of mental health and incapacity legislation

On the day of the visit, 13 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and covered all treatment prescribed. These were recorded on EMIS and a paper copy held in the treatment room.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We found evidence that patients were being made aware of this safeguard and where there was a named person this was recorded.

In relation to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), where the person had granted a Power of Attorney (POA) or was subject to welfare guardianship, this was recorded on EMIS, and copies of the powers were available in all the files we reviewed. There was evidence throughout the chronological notes and MDT minutes of consultation with proxy decision makers in relation to care and treatment.

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; this is required in law. The certificate 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. We found completed forms and records of communication with families and proxy decision makers in all the files we reviewed.

For people who were receiving medication covertly, a completed covert medication pathway was in place, in line with the Commission's recommendations, and there was information from pharmacy on how to safely administer the medication.

Rights and restrictions

Both wards continue to operate restricted entry, commensurate with the level of risk identified in the patient group. There was a policy and information on how to enter and exit the ward was available near the door in both wards.

We were told that the wards have open visiting.

We saw posters advertising the local advocacy service in Jura Ward, and this information was contained in Isla Ward's admission information leaflet. We found evidence in the care records of advocacy services being accessed by patients.

When we are reviewing individuals' 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 found one advance statement on file.

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.

Activity and occupation

The wards has input from two therapeutic activity nurses who provided a comprehensive activity programme. There is activity provision throughout the day, including a wide variety of group and individual activities which people can choose to attend, such as relaxation groups, quizzes, pamper sessions, reminiscence, musical activities, crafts and games.

There was evening and weekend activities with regular outings to concerts, theatres and a wide variety of local community facilities and groups using the minibus. We were pleased to find meaningful recording of participation and outcome of activities in the files we reviewed.

The physical environment

The wards were bright and spacious, décor was generally good, although in Isla Ward, one of the small sitting rooms would benefit from repainting. The atmosphere in both wards was warm and welcoming. There were several quiet spaces as well as the large sitting areas.

Murals and pictures of local Glasgow scenes around the wards added interest to the environment, as did the memory walls.

There are well-designed, secure gardens with plenty of seating; these spaces were clearly well used. There were outdoor games and planters, which are used by the gardening group organised by the occupational therapist.

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

In Jura Ward there was a large room that was used as a flexible space for recreational and therapeutic activities. This could also be used for families to visit patients, however visitors were also encouraged to use the person's room for visits.

In our previous visit to Isla Ward, we made a recommendation that the use of magnetic replacement doors for ensuite bathrooms should be reviewed. During this visit we found that these had been removed as they were found to be unsuitable and posed a potential falls risk. However, no replacement solution has been found and currently the en-suites in Jura Ward have no doors. This leaves people exposed and compromises their dignity. In Isla ward we were told that despite the heavier magnets now used the doors are easily detached, however they are there and people who wish to have them in place do have them, however in the majority of rooms they were absent.

Recommendation 2:
Managers must urgently address the issue of the absence of doors on ensuite bathrooms to provide a safe and dignified environment.

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 shows reflects the patients' progress and supports the delivery of person-centred care.

Recommendation 2:
Managers must urgently address the issue of the absence of doors on ensuite bathrooms to provide a safe and dignified environment.

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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