Mental Welfare Commission for Scotland

Report on announced visit to:
Nairn Ward, Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UZ

Date of visit: 22 October 2024

Where we visited

Nairn Ward is a 21-bedded unit in Stobhill Hospital that provides acute mental health admission. On the day of our visit, there were 21 people on the ward with no vacant beds.

Nairn Ward is managed offsite by Dykebar Hospital, covering the Renfrewshire area. The service is usually located in Ward 3b, Leverndale Hospital but has been temporarily moved to Nain Ward, to allow necessary health and safety work to be carried out. The service is expected to return to Leverndale Hospital in June 2025.

Narin Ward has responsibility for Esteem, which is a mental health service for individuals aged between 16 and 35 years old, who are experiencing a first episode of psychosis.

We last visited this service in November 2023 on an announced visit and made recommendations on review of risk assessment documentation and providing written notification to individuals who were made specified persons. The response we received from the service was that all risk assessments are now reviewed at the multidisciplinary team (MDT) meeting, with charge nurses (CN) auditing care records. We were also advised that individuals are now routinely provided with written notification regarding their rights and notified of the timescales involved if they have been made a specified person.

On the day of this visit, we wanted to follow up on the previous recommendations and hear from individuals, their families and/or carers as well as staff about the transition between Leverndale and Stobhill hospitals.

Who we met with

We met with nine people and we reviewed the care notes of seven. We also spoke with two relatives.

We spoke with the service manager (SM), CN, the lead nurse (LN), occupational therapy (OT) team, nursing staff, bank staff and a consultant psychiatrist.

Commission visitors

Gemma Maguire, social work practitioner

Margo Fyfe, senior manager

Ahmad Allam, trainee psychiatrist

What people told us and what we found

We heard from most individuals that we met with that staff "can't do enough to help" and deliver the "best" of care. Relatives we met with told us that staff provided updates regarding their loved ones, and they feel able to express their views.

We were particularly impressed by the planning undertaken to prepare individuals, their families and staff for the transition to Nairn Ward. We heard how the service used a local mental health network and advocacy services to support conversations with individuals and their families about the transition. We were also informed that Nairn Ward has daily access to a bus which operates between Stobhill Hospital and the surrounding area of Leverndale Hospital, transporting individuals, their families and advocacy services. The transport service has helped individuals to maintain links with their local community as well as support contact with family and friends, which the Commission recognised as an important aspect of an individual's recovery.

The Commission are aware that other NHS Greater Glasgow and Clyde (NHS GGC) services are undergoing health and safety work and would advise managers to share the good practice in Nairn Ward for any future plans where a move such as this is required, as it helped prepare individuals for the planned move.

Some individuals we met with told us that bank staff on the ward seem less "skilled" and at times less "caring" compared to permanent staff members, although we heard from team members that we met with that bank staff are crucial to help the service maintain safe and consistent levels of cover. We met with bank members of staff who informed us that they had been provided with a wide range of training, however formal supervision was not routinely carried out, and if there were any issues relating to practice, these were reported and dealt with by the managers of each ward.

We discussed these issues with CN and LN on the day of the visit. The LN confirmed that individual concerns are investigated and escalated appropriately by NHS GGC as per the procedure. The CN advised us that the move to Stobhill Hospital has meant the service have lost some of their regular bank staff. The Commission are of the view that appropriate levels of supervision should be provided for all staff and will continue to follow this up with the service.

On the day we visited, we were advised by the SM that several people were boarding out in other wards due to lack of bed capacity across inpatient mental health services in NHS GGC, as well as nationally. We were informed that four individuals were boarding out in older adult wards. We heard how staff are regularly taken from Nairn Ward and other acute mental health admission services to support and manage risks associated with individuals who are boarding out. One person we met

with told us they waited three weeks in a medical ward for an acute mental health inpatient bed which delayed access to care and treatment. We discussed these issues with LN and CN on the day of our visit. We were advised that managers continued to have daily bed management meetings to discuss where there were risks and prioritised resources. We were informed that individuals would usually be transferred to acute adult admission services within days, however in times of increased demand, people have boarded out for longer periods. The Commission will continue to follow up with the service regarding these issues.

Care, treatment, support, and participation

Care records

All care records, including care plans, MDT records and risk assessments, were accessible on the electronic recording system, EMIS. We were advised that NHS GGC have introduced a new document for recording care plans, and while we found some person-centred care plans, this was not consistent.

We found several care plans to be overly descriptive with repetitive and generalised use of language, as opposed to providing meaningful individualised details. Whilst those we met with were aware of their goals, the recording of reviews did not detail progress towards person-centred goals.

Staff we met with told us that they were required to upload a new document each time a care plan was updated and/or reviewed, which was 'clunky' and time consuming. At the time of our last visit, we commented on the good progress made by the service in relation to person-centred care planning and individualised goals. We were disappointed that the new document has not supported the service to maintain this standard.

Recommendation 1:
Managers should carry out an audit of nursing care plans and reviews to ensure they reflect progress towards individualised goals with recording systems fully supporting practice.

We discussed these issues with CN and LN on the day of our visit and were advised that managers are consulting with staff on the implementation of the new document and these issues will be fed back.

We were pleased to note that since our last visit, all risk assessment documentation has been reviewed and updated accordingly. Whilst risk assessments were detailed, at times we found them to be repetitive and lengthy. On the day of the visit, we advised the CN and LN to ensure that the most relevant information about risk was clearly recorded in care notes.

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)
MDT meetings are held weekly in Nairn Ward and include two consultant psychiatrists who also oversee the care and treatment of individuals who are admitted via Esteem.

At the time of our last visit the service had a dedicated Esteem psychiatrist, however this post did not move to Nairn Ward due to service pressures in other areas. We were advised that the Esteem psychiatrist will be available when the service returns to Leverndale Hospital. Other Esteem nursing and support staff continue to visit individuals on the ward, and psychiatrists can consult with Esteem colleagues when required.

MDT meetings also include pharmacy, OT and psychology.

MDT meetings were recorded weekly with the person's view evident in the record of the meeting. However, details such as who attended the meeting and/or clear action points that related to individualised goals were not consistently recorded. The Commission are of that view that MDT meetings should be clearly and consistently recorded to capture discussions and agreed actions as part of person-centred care planning.

Recommendation 2:
Managers should audit MDT records to ensure discussions and agreed actions which relate to individualised goals are consistently recorded.

Use of mental health and incapacity legislation

On the day of the visit, 14 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All individuals who were detained under the Mental Health Act were aware of their rights. All documentation relating to the Mental Health Act was clear and accessible.

Several individuals had nominated a named person, were receiving legal advice and accessing advocacy services.

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. Consent to treatment certificates (T2) and

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

certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

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 this was clearly documented in records with the named person appropriately consulted and views recorded.

All the individuals we met with and/or reviewed during this visit had capacity to make decisions, including consenting to medical treatment and were not subject to the Adults with Incapacity (Scotland) Act, 2000.

Rights and restrictions

Several people we met with on Nairn Ward were admitted on an informal basis, meaning they were not subject to detention under the Mental Health Act and could leave the ward, and hospital grounds, if they choose to do so. Some individuals who were admitted informally had 'pass plans' in place which is an agreed plan between the MDT and the individual regarding time out of the ward and/or hospital.

The Commission understands that for some individuals, these plans can form part of the recommended treatment which may be appropriate and lawful, as long individuals understand their rights, and are able to fully consent to the plan. However, the views expressed by some that we spoke with indicated this has not always been understood. Whilst the individuals we met with were agreeing to admission, and wanted to remain in hospital, some believed they "were not allowed to leave the ward" without staff permission.

The care records we reviewed did have information about 'pass plans', but as we would have expected to see, there were no detailed discussions and/or recorded consent from individuals. We discussed with CN and LN on the day of our visit and were advised that individualised 'pass plans' are agreed verbally with individuals. We suggested to the senior staff in the service that information should be provided to individuals verbally, and in writing, to ensure their rights are clearly understood.

Recommendation 3:
Managers should ensure individuals who are admitted informally to Nairn Ward are fully advised of their rights, verbally and in writing. They should check individuals understand their rights when being asked to consent to recommended treatment, including being advised not to leave the ward/hospital.

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. On the day of our visit, no one was specified under the Mental Health Act.

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 copy in files and noted that where there was an advance statement, these were reviewed at MDT meetings. Information on writing an advance statement was available on the ward notice board.

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

We commented on the wide range of choice and availability of activity and OT at the time of our last visit. We are pleased to note that despite moving to a different hospital, the OT services, along with support from nursing staff have continued to provide a range of meaningful group-based, and one-to-one activities.

Activities include relaxation groups, recycling initiatives and walking groups. The OT team have also developed links with neighbouring mental health wards and secured access to kitchen areas which has provided functional assessments for individuals in preparation for discharge.

The physical environment

The layout of the ward consists of single ensuite rooms and shared dormitories. During previous visits to Ward 3b at Leverndale Hospital, we have commented on the tired appearance of the environment. We were pleased to note that Nairn Ward had a bright and spacious environment.

The SCN confirmed that Ward 3b will be fully decorated when the service returns to Leverndale Hospital next year. We look forward to hearing of progress with this work.

Nairn Ward has direct access to a spacious garden with various seating areas. On the day of our visit, we observed a bin with an ashtray in the garden which contained several used cigarettes. The Commission is aware it is illegal for anyone to smoke in hospital grounds in Scotland and discussed this issue with LN and CN on the day of our visit. We were informed that individuals are advised not to smoke on hospital grounds and despite nicotine replacement therapy (NRT) being available, some

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

individuals continue to smoke in the garden area. The LN and CN confirmed the service do have policies in relation to hospital buildings being smoke-free. However, they expressed concern that enforcing these policies on individuals who experience acute symptoms of mental disorder and have a nicotine addiction could cause distress. The Commission are clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While the Commission understand that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other inpatient services are enforcing smoking bans and utilising NRT. We advised LN and CN to consult with other services who are adhering to policies for further advice and learning.

Recommendation 4:
Managers for Nairn Ward should ensure that legislation and local procedures are adhered to in relation hospitals buildings being smoke free.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of nursing care plans and reviews to ensure they reflect progress towards individualised goals with recording systems fully supporting practice.

Recommendation 2:
Managers should audit MDT records to ensure discussions and agreed actions which relate to individualised goals are consistently recorded.

Recommendation 3:
Managers should ensure individuals who are admitted informally to Nairn Ward are fully advised of their rights, verbally and in writing. They should check individuals understand their rights when being asked to consent to recommended treatment, including being advised not to leave the ward/hospital.

Recommendation 4:
Managers should ensure that legislation and local procedures are adhered to in relation hospital buildings being smoke free.

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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