Mental Welfare Commission for Scotland

Report on announced visit to: Tate Ward, Gartnavel Royal Hospital, 1053 Great Western Road, Glasgow, G12 0YN

Date of visit: 18 May 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Routemap (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Tate Ward is a 20-bedded adult mixed-sex ward based in Gartnavel Royal Hospital. We last visited this service on 16 July 2019 and made recommendations regarding care plans and therapeutic activity provision.

On the day of this visit we wanted to follow up on previous recommendations and also meet with patients and speak with their relatives. We also wanted to hear from staff of their experience of caring for patients during the Covid-19 pandemic. This is because we were aware from local intelligence in-patient services saw a significant rise in mental illness acuity. Furthermore, with restrictions in place there was a reduced opportunity for patients to have input from allied health practitioners, therapeutic activity away from the ward environment and visits from friends and relatives.

Who we met with

We met with and reviewed the care and treatment of six patients, and by telephone we spoke with two relatives. Prior to our visit we met with the senior charge nurse (SCN), two deputy charge nurses, and have been in regular communication with the hospital management team.

We are aware the SCN for the Tate Ward will be retiring and a new SCN has recently been appointed. We will look forward to meeting the new SCN during our future visits to Tate Ward. In addition on the day of our visit we met a charge nurse, members of the clinical team, mental health officer (MHO) and the newly appointed in-reach senior crisis practitioner.

Commission visitors

Anne Buchanan Nursing Officer

Margo Fyfe, Senior Manager

What people told us and what we found

Care, treatment, support and participation

On the day of our visit all beds were occupied with levels of bed occupancy having remained high over the past 12 months. Nursing staff told us there has been an increase in acuity, and patients admitted from the community have been exceptionally unwell.

There is a view that social isolation, reduced service provision and anxiety in relation to the Covid-19 pandemic have attributed to an increase in mental health distress. There is a sense that patients' duration in hospital has been longer than in previous years.

Anecdotally, nursing staff believe with the reduction in community services, for example, local authority provision, patients are having to wait for repairs to their tenancies or indeed packages of care. This has meant discharges from hospital based care have been hindered.

We met with the newly appointed in-reach senior crisis practitioner. This new role is seen as a bridge between inpatient wards, community crisis service, and community mental health team. We heard this innovative approach for Gartnavel Royal Hospital was considered a priority to support patients in the early days of their admission especially if issues at home are linked to their mental health deterioration. Furthermore, the in-reach model lends itself to reducing barriers to discharge. The in-reach practitioner takes an assertive position by ensuring services are able to meet the individual's specific needs thus promoting a sustainable discharge back home. We welcomed this new role and look forward to hearing of its progress during our next visit.

On the day of our visit patients we spoke to were positive about their care and treatment. Interactions between nursing staff and patients were warm and staff were knowledgeable about the patients in their care. We met with an MHO who also spoke positively about their experience working with the nursing team. This collaborative approach to working with community and local authority services was highlighted as an important part of the daily work carried out by members within the multidisciplinary team (MDT).

The MDT meet weekly to review care and treatment of each patient. We saw input from medical, nursing and allied health professionals as part of the weekly reviews. We were told the new in-reach practitioner will be attending MDT meetings to assist with identifying patients who may require a referral for additional or intensive support post discharge from hospital.

Relatives we spoke to were positive about the care and treatment their relatives had experienced. While restrictions brought about by the pandemic have meant opportunities to visit friends and relatives has been significantly reduced, there was a view nursing staff have made huge efforts to maintain contact, provide regular updates ,and organise visiting schedules to ensure families can keep in touch with each other.

There were some concerns raised by relatives about the policy of self-isolation for five days following admission to hospital. Relatives accepted and recognised the need for this as part of reducing the risks associated with Covid-19 transmission. However, they were concerned

patients were left in their bedrooms with very little to occupy their time. While admission may have been required due to the seriousness of a patient's illness, there was little in the way of therapeutic engagement or at the very least a television or iPad to occupy their time during the isolating period.

We accept this policy is likely to continue due to the nature of Covid-19; to that end it would seem sensible to introduce opportunities for patients who do have to self-isolate a programme of activities based upon their interests and hobbies.

On the day of our visit we met with and reviewed the care of six patients. We were keen to review documentation in relation to progress notes and care planning. This is because during our last visit we were concerned care plans were not considered patient-centred, limited evidence of patient participation or regularly evaluated.

Unfortunately, we were not able to ascertain any progress and identified a patient admitted the previous month did not have any documentation relating to care plans. This would suggest the nursing process for delivering care and treatment was not regularly reviewed nor discussed with the patient to assess their needs and agree goals for this admission to hospital.

Again, we found inconsistent practice in relation to completion of care plans. Some had a lack of detail and were not regularly evaluated; therefore it was difficult to determine whether interventions were helpful.

Care plans did not provide evidence of patient participation, were not signed and patients we spoke to were not able to tell us what was in their care plan that would help with their recovery. We highlighted this on the day of our visit to the charge nurse; we were concerned specifically about the absence of a care plan for one individual but also about the lack of improvement and progress since our last visit.

Recommendation 1:

Managers should at the earliest opportunity review and regularly audit the current care plans to ensure that they reflect the ongoing care and treatment being provided.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Of the patient' electronic and paper notes we reviewed, there was some evidence of one-to-one meetings taking place between patients and nursing staff.
However, due to the lack of detail, it was difficult to assess whether patients were progressing during their admission to hospital. Moreover, the daily record of contact with patients lacked a richness to the narrative.

We would like to have seen details of therapeutic engagement taking place and a subjective view from patients about their progress. We were told while there has been an increase in agency and nursing bank staff, the core team have remained consistent and would therefore expect a greater quality of detail in patient's daily notes.

Recommendation 2:

Managers should ensure the daily record of contact between nursing staff and patients is meaningful, and includes both a subjective and objective account of the patient's presentation.

Recommendation 3:

Managers should ensure regular audits of progress notes to ensure consistency of record keeping and assist with reviews.

Use of mental health and incapacity legislation

On the day of our visit 14 patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Of those patients subject to compulsory treatment, we reviewed the legal documentation available within their files.

Paperwork relating to treatment under part 16 (sections 235 -248) of the Mental Health Act was in good order. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were in place where required.

Rights and restrictions

On the day of our visit there were three patients on an enhanced level of observation. Patients who require this level of observation are reviewed daily by the clinical team to determine whether this level of observation is required. While decisions relating to levels of observations are largely determined by the clinical team, senior nurses are given authority to reduce levels of observation, thus reducing the risk of patients remaining on enhanced level of observation unnecessarily.
We were told Tate Ward operates a controlled door entry system, and patients are provided with the code to allow them access to come and go from the ward. The nursing team undertake regular environmental checks which include opportunities to engage with patients. On the day of the visit the ward was calm and quiet although it is recognised that this is not always the case and depends on the patient population at any given time.

We were told patients have access to independent advocacy and legal representation. During the pandemic, face-to-face meetings between patients and their legal representatives or advocacy support workers have been largely undertaken by telephone. The Mental Health Tribunal for Scotland continues to provide teleconferencing facility for hearings. Anecdotally, ward staff have found patients are happier to attend their hearings by teleconferencing rather than in-person, have found the experiencing less threatening, and feel professionals engage well with them during 'virtual hearings'.

Ward staff, including MHOs, provide information about how to access legal representation and support from independent advocacy services. Leaflets and contacts are made available and access to telephones and privacy are encouraged in order for patients to seek representation during their admission to hospital.

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 in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

While we appreciate the pandemic has had an unwanted impact on the everyday schedule of therapeutic activities based in and around the hospital site, we were disappointed to learn the possibility of a patient activity co-ordinator post for Tate Ward has not happened. We recognise the importance of therapeutic activities and we were told by patients they value the interactions they have with staff either one-to-one or in small groups. However, we were told additional activities with a timetable would be greatly appreciated. Having a dedicated member of the team to invest time and energy into an imaginative therapeutic programme would be welcomed.

We were told the Hub based in the main part of the hospital will be offering more activities as restrictions are eased; however the geographical distance from Tate Ward to the Hub has put off patients from attending. We discussed this issue with senior staff on the day of the visit; they recognise the benefits of therapeutic activity and are aware discussions are continuing in relation to a patient activity co-ordinator post.

Recommendation 4:

Managers should ensure a structured activity timetable is available for all patients. Patients who have restrictions place upon them and therefore unable to attend the Hub should be provided with activities based upon their areas of interest or need.

The physical environment

The ward is bright, clean and well maintained. There are quiet areas for patients to spend time in and space for patients and staff to socialise. Due to Covid-19, staff are required to wear personal protection equipment (PPE) namely face masks with the addition of aprons / gloves when interacting with patients who are required to self-isolate. It was good to observe staff and patients interacting very well.

With the possibility of PPE restricting natural interactions, it seemed staff were making huge efforts to support and connect with patients while accepting current conditions are outwith the 'norm' of the ward milieu.

Currently, the practice of sending laundry away to be washed and dried continues and this is a source of frustration for nursing staff and patients. There are ongoing issues with clothing

getting lost and not returning to the ward. Equally, nursing staff believe not having washing facilities at ward level inhibits patients to continue with independent living. We would welcome the addition of a laundry on the ward. We are aware patients would welcome the facility to enable them to wash their own clothing.

Summary of recommendations

1. Managers should at the earliest opportunity review and regularly audit the current care plans to ensure that they reflect the ongoing care and treatment being provided.

2. Managers should ensure the daily record of contact between nursing staff and patients is meaningful, and includes both a subjective and objective account of the patient's presentation.

3. Managers should ensure regular audits of progress notes to ensure consistency of record keeping and assist with reviews.

4. Managers should ensure a structured activity timetable with activities is available for all patients. Patients who have restrictions place upon them and therefore unable to attend the Hub should be provided with activities based upon their areas of interest or need.

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.

ALISON THOMSON
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 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk