**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Clyde House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

**Date of visit:** 12 September 2022

## Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Clyde House is an 18-bedded high dependency, mixed-sex intensive rehabilitation ward providing care and treatment for adults with severe and enduring mental health problems. The rehabilitation service in Gartnavel Royal Hospital consists of two wards, Clyde House and Kelvin House. The function and configuration of these two wards was revised in 2017 and the rehabilitation service as a whole is currently under review as part of the city-wide rehabilitation review group.

At present, the bed configuration in Clyde House is that 14 beds are for patients requiring a slower paced rehabilitation journey, and four hospital-based complex care beds for patients who may have more complex needs and for a variety of reasons, present with behaviours that can be challenging. The ward can accommodate 18 beds for patients but at present they have three beds out of commission.

We last visited this service on 18 May 2021, we made recommendations for a review of the occupational therapy provision, that all treatment was authorised and implemented appropriately, that the ward was welcoming, fit for purpose and updated, and that single room accommodation was provided for the benefit of patients.

## Who we met with

We met with three patients, and reviewed the care and treatment of seven patients. We spoke to the senior charge nurse (SCN), the occupation therapy (OT) team and the Consultant Clinical Psychologist.

This local visit was undertaken using a combination of telephone contact with staff and senior managers prior to the visit and face-to-face contacts on the day of the visit. As part of our visit we held telephone meetings with families of patients.

## Commission visitors

Justin McNicholl, social work officer

Mary Hattie, nursing officer

# What people told us and what we found

## Care, treatment, support and participation

The patients we met with during our visit spoke positively about their care and treatment on the ward. All staff were described as “fantastic” and “going above and beyond” when providing care to patients. Patients were aware of having a named nurse and were able to have one-to-one sessions with them when required. Patients were aware that they could speak to their doctor if they wished to and could attend weekly clinical meetings. We were pleased to hear that where individuals were detained, they were aware of their rights and had access to advocacy and legal representation. We had sight of various notice boards on display in the ward which promoted patient’s rights and helped to inform them of how to access these. The ward environment was described as calm and peaceful. Food was rated positively. Patients talked extensively about the variety of activities that they participated in, which included playing pool, attending social groups, making meals, going out for walks with staff to the local shops, and undertaking exercise.

We heard from managers that on occasion, staffing has been a challenge for the ward when patients required higher levels of observations. To meet this demand, bank staff are brought in. These staffing demands were further compounded by the Covid-19 pandemic which has had a negative impact on staffing levels. We heard from senior management that the vacancy rates for nursing staff for the ward continue to be prioritised. Despite this, we heard from a number of patients who noted that compared to other wards on site that they had stayed in, the staff in Clyde House were “kind” and “brilliant”.

We were advised of vacancies in psychology posts which is a service-wide issue. Despite these vacancies, we heard from patients about their positive experience from psychology input that they have been receiving during their time in Clyde House, with clear formulations available for all patients to help staff deliver the most appropriate care. We noted that over the last year, having consistent psychiatry cover for the ward has helped to provide stability to patients and staff. We heard that following our recommendation regarding OT provision to the ward, there has been significant improvements. This was evidenced in all the patient’s records that we read, with detailed OT assessments and recommendations. We were pleased to see that physiotherapy support has been prioritised on the ward, with access to well-being support available. This provision, along with the local volunteer co-ordinator at Gartnavel Royal Hospital, has helped to ensure a variety of social activities, groups and volunteering opportunities for patients, to minimise any risk of isolation in the service.

We found good evidence that all physical health care was being delivered and available with patients having good access to the local general practitioner, who provides physical health care.

### Care plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

During our visit, we saw a range of detailed and person-centred care plans which addressed both physical and mental health care needs. The care plans identified needs and outlined interventions and agreed goals to meet needs, which included discharge planning. There was evidence of patient participation and reasons, where appropriate, for non-engagement. Each patient had a risk assessment on file, which again was comprehensive and showed evidence of appropriate interventions and strategies to manage risk. Care plans and risk assessments were regularly reviewed. Overall we were impressed with the quality of both care plans and risk assessments.

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/node/1203

On the day of our visit we were told that no patients were delayed discharges. This means that all patients in the ward had a clinical requirement for admission and there were no current barriers in securing community care packages or placements.

### Multidisciplinary team (MDT)

The use of regular multidisciplinary team meetings (MDT) is vital to ensure that all professionals, named persons and the patient are aware of the care planning for patient care.

During our visit we found MDT meeting notes in all patient records for the ward. We heard from patients that they would routinely attend their MDT meeting and were included in discussions regarding their care. Named persons (NP) and their nearest relatives advised that they were invited to attend the MDT in person, or online, during the Covid-19 pandemic. This flexibility of engagement with NPs and nearest relatives has helped to facilitate clear communication and identified plans for all patients care. There remains ongoing issues with the attendance of psychology and pharmacy staff at the MDT, due to demands on these professionals and vacancies. Despite this, managers report that both professions will attend when and where they can, to ensure that informed decisions are made swiftly to minimise delays in patient care.

### Care records

Information on patients' care and treatment is held mostly electronically on the EMIS system. Some information is held in paper files and is currently being migrated over to EMIS. The daily progress notes regarding patients care and treatment was detailed and showed evidence of one-to-one input or when reassurance was offered. In the daily progress notes, there was input from other professionals such as OT, pharmacy and social work mental health officers (MHOs) which was well documented. Similar to our last visit, we again found detailed person-centred care plans that evidenced patient involvement that helped patients understanding of their care in a meaningful way; the care plans addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. All care planning was completed to a high standard which helped to inform risk assessments and management plans.

## Use of mental health and incapacity legislation

When a patient is subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003, (the Mental Health Act), we would expect to see copies of all legal paperwork in the patient files. Part 16 (S235-248) of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments.

During this visit, we wanted to follow up on our previous recommendation regarding the anomalies we found in T2 and T3 documentation. We reviewed the certificates which record consent to treatment under the Mental Health Act (T2 and T3 certificates). We found these certificates in the patient's paper files. We were pleased to see clear and consistent recording of the legal authority and circumstances under which medication was being given.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (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. In reviewing patient's files, we were able to locate all s 47 certificates and treatment plans for physical health care. We were pleased to note that there was clearer consistency regarding the use of s47 certificates on this visit.

All documentation pertaining to the Mental Health Act and AWI, including certificates, were available and up-to-date. Any patient who receives treatment under the Mental Health Act or Criminal Procedures (Scotland) Act 1995 (CPSA) (where applicable) can choose someone to help protect their interests; that person is called a named person (NP). Where a patient had a nominated NP, we found copies of this in the patient's file.

There was one patient who was subject to a guardianship order under the AWI Act. A copy of the powers in the order could not be located in the patient file. A request has been made to the guardian to ensure this was shared and then noted in the patient file. Despite there not being a copy on file, there was a clear understanding of what this order authorised from the staff we spoke with.

## Rights and restrictions

Clyde House is an open ward operating a touch keypad access which all the patients are aware of and use. We were satisfied this was proportionate in relation to the needs of the patients. Although restrictions due to the Covid-19 pandemic have lifted, the ward continues to place the safety of patients at the forefront of any visits the ward.

When we are reviewing patient files we found no copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 in the future. Health boards have a responsibility for promoting advance statements. Despite the lack of advanced statements we were pleased to see that a project is being led by the SCN to increase the uptake of these statements. We would encourage the service to revisit this with all patients as it is an important safeguard and a way

of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts made to engage patients in a discussion regarding advance statements and the reason noted for any patient that does not have one.

We were informed that all patients detained under the Mental Health Act were referred to advocacy by their MHO and/or nursing staff. We were pleased to hear that advocacy services have resumed face-to-face visits.

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

During our visit, we wanted to follow up on our last recommendation regarding the lack of provision of OT staff to the ward. We were pleased to hear of the increased sessions supplied by the OT and OT assistants to ward. We were also pleased to hear that the OT input on the ward was making a difference for patients, with increased activities befitting a rehabilitation ward. We were told that patients are involved in decisions regarding the provision of activities on the ward and that activities are offered based on patient interest, and these activities aim to provide routine and structure. Activities are discussed at the weekly patients' forum and patients have access to a timetabled activity structure developed form this. During our visit we saw these activity timetables on display on the ward. We heard that activities take place seven days per week, including evenings.

We also heard about the close working links between the volunteers coordinator for Gartnavel Hospital and nursing and OT staff that has helped to deliver opportunities for patients. Managers acknowledged that many activities in the community, for instance bowling, swimming and tennis, had to stop due to the Covid-19 pandemic, although creative ideas were put in place by staff in order to support positive outcomes for patients during this time. Despite these attempts, a number of barriers remain in place making it difficult for patients to easily access activities, for instance pre-booking is required now for most community activities. Not all patients have access to debit cards to make advance payments for services and many businesses no longer accept cash. Staff have made attempts to address these barriers when undertaking visits to the local cinema or leisure centre with variable success. When we next visit the service we will be keen to hear how this has progressed.

## The physical environment

The ward comprises of six single bedrooms and three four-bedded dormitories. As highlighted in our last visit report in 2021, this remains an unsuitable environment for an in-patient mental health ward. Many wards across NHS Greater Glasgow and Clyde have been refurbished to provide patients with individual rooms. We continue to find it disappointing that since our last visit there has been no progress to ensure privacy and to protect the dignity of the patients in this ward. This is especially relevant given the fact that patients who are cared for, and engaging in a rehabilitation service, can be in hospital for lengthy periods of time. Despite this, the ward itself was found be clean and tidy.

The ward benefits from a number of communal areas including a spacious sitting/dining room, activities room and a private garden space, which was bright and welcoming. We were able to observe that patients were encouraged to personalise their rooms, which helped to provide a homely environment. We heard from managers of plans to refurbish the garden space, to allow it to be utilised for gardening activities that would benefit patients. We observed that a new pool table had been purchased for patients, which would provide them with social opportunities, as well as new projector and screen to allow patients to hold cinema nights. We noticed that there were some cosmetic improvements to the ward however, we consider that the rehabilitation service would benefit from complete refurbishment. We were told that plans for a major refurbishment have been spoken about for a number of years, however this has never been progressed.

**Recommendation 1:**
Managers should ensure that the ward environment is welcoming, fit for purpose and provide the Commission with an update on the programme for refurbishment, including timescales.

**Recommendation 2:**
Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that the ward environment is welcoming, fit for purpose and provide the Commission with an update on the programme for refurbishment, including timescales.

**Recommendation 2:**
Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

## 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.

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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