Mental Welfare Commission for Scotland

Report on announced visit to:

Rutherford Ward, Gartnavel Royal Hospital, 1053 Great Western Road, Glasgow G12 0YN

Date of visit: 26 October 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.

Rutherford Ward is a 20 bedded mixed-sex unit divided into two ward areas, with a central corridor where all clinical activity takes place and offices are located. The unit provides in-patient acute assessment and treatment for adults who have a diagnosis of mental disorder. On the day of our visit there were several new admissions who had a first presentation of mental illness. The ward serves Drumchapel and Bearsden in Glasgow and Helensburgh in Argyll and Bute. The ward has links to Community Mental Health Teams in the Arndale Centre, Drumchapel and the Jeanie Dean Centre, Helensburgh. The ward is also the designated ward for in-patient admission from the Ministry of Defence facility at Faslane.

On the day of our visit there were no vacant beds. There were three patients who were on enhanced observations and this had a significant impact on staff.

We last visited this service on 23 July 2019 and made recommendations in relation to auditing care plans and reviews; to ensure that care plans were person-centred and reflected individual patient needs and participation; that MDT notes reflected the discussion and decisions taken; that there was a record of one-to-one sessions; that the clinical team met with relatives and carers for their views and that the garden area was a pleasant experience for patients using it.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the recent pandemic.

Who we met with

We met with, and reviewed, the care of six patients, five whom we met with in person and one patient whose care notes we reviewed. We also spoke with one relative on the telephone.

We spoke with the senior charge nurse, and the two charge nurses and some of the wider nursing staff group on duty. We also met with the peer support worker.

Commission visitors

Anne Craig, social work officer

Justin McNicholl, social work officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patient group well. It was good to hear from the patients that we met that they had high praise for staff, although one patient commented that they did get frustrated as she was cared for by "a different person every day".

We heard about the work that had gone into supporting carers/families during the restrictions. There had been additional iPads made available to the unit to encourage online contact between patients and families.

In the past, we had been concerned about patients being on the ward for extended periods of time as delayed discharges. We were pleased to hear that at the time of our visit there potentially was one patient whose discharge from hospital was delayed; this was due to family circumstances as there were plan for the patient to return to live with family at home.

The staff at Rutherford Ward take pride in their work and showed us that this has been acknowledged by a local MSP who had presented a motion in the Scottish Parliament to recognise the work undertaken in the ward. However, one of the staff described the recent staffing levels as "horrendous". The ward has a core staff team, which at the time of our visit was only 25%; this was apparent with additional staffing provided by agency and bank staff who were on duty that day.

We met with the peer support worker who has been in post for 16 years. They were enthusiastic and fully engaged with the role. We heard how the peer support worker is available to patients on their terms. It is our view that this is a valuable role, particularly in in-patient settings and offers patients a forum to spend time with someone who understands their issues from a non-clinical perspective.

Care plans

When we last visited the service, we highlighted concerns about care plans that lacked the detail we would have expected. We also felt the care plans could have been more person-centred. We expected care plans to have addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. On this occasion, we found that care plans had improved but we thought that they could be more person-centred and there should be more evidence of patient involvement. We saw that physical health care needs were being addressed, and followed up appropriately with allied health professional input, including dietetics and speech and language therapy.

When we reviewed the current patient care plans we noted that while reviews were taking place, they lacked the detail we would have expected to see, especially toward the patient's recovery. We discussed this with the senior charge nurse and the nurses on duty. We were aware that in the service, care plans and reviews are being worked on and we suggested using the Commission guidance on our website to help in the process. We recommended that an audit of the care plan reviews was carried out, to ensure that they reflect the work being done with individuals towards their recovery goals, and that the reviews are consistent across all care plans.

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

Recommendation 1:
Managers should carry out an audit of the nursing care plans and reviews to ensure they fully reflect the patients' progress towards stated care goals and recovery and that recording of reviews are consistent across all care plans.

Care records

Information on patient care and treatment was held in a paper file, and also on the electronic record system EMIS. We noted that information on the electronic recording system would have been helpful had it been immediately available in the paper file, in the event of an emergency. There was no indication of where specific pieces of information were located. We were of the view that there was a risk of information going missing. We discussed this on the day of the visit and were assured that discussions were ongoing with the IT department to ensure that going forward most information can be saved to the EMIS system. We suggested that as an interim measure, a list be created in the paper file that detailed where specific information could be located.

The daily care notes on EMIS were concise and gave a good understanding of the patient's presentation and activity throughout their journey and were a valuable tool informing the reader of any changes. There was evidence of patients having one-to-one time with their named nurse but not all of the patients wished to take part, mainly due to the acuteness of illness at the time.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) consisting of nursing staff, psychiatry, occupational therapy staff, speech and language therapy staff and psychology staff. Referrals can be made to all other services as and when required. However, it was not clear from the MDT meeting notes who attended or what decisions had been made. There were a few instances where we could see that the patient had taken part in the MDT meeting, some recordings of where they were not present, or where information from the meeting had been communicated to them and/or their relatives/carers. We were advised that on the day of the meeting, that patients and their carers are encouraged to attend the MDT and that everyone's views are taken into account. We heard that meetings had been held online during the pandemic and that this had enabled more professionals to attend. MDT meetings have now reverted to in-person, on site, meetings.

We were unable to find clear discharge planning information in the MDT meeting notes. When we spoke with staff on the day of the visit, we highlighted that this should be added to the meeting note, where appropriate.

Recommendation 2:
Managers should ensure that there is a clear record of the attendance at the MDT, the decisions made and who will be responsible for updating the patient and/or their relatives and carers if they had not been in attendance.

Use of mental health and incapacity legislation

On the day of our visit, 15 of the 20 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act.

All documentation pertaining to the Mental Health Act and the Adults with Incapacity (Scotland) 2000 Act (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed. We found that all T2s and T3s had been completed by the responsible medical officer, they were available and up-to-date.

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 copies of this in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of AWI 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. There were no patients in this category on the day of the visit.

Rights and restrictions

Rutherford ward operates a locked door using a keypad; this is commensurate with the level of risk identified with the patient group. The keypad number is available for informal patients and visitors and there is a notice at the door with the keypad number and instructions on how it is used. Use of the keypad is monitored by staff.

Visiting has returned to normal levels and there are no restrictions. We saw copies of the admission and discharge information leaflets for patients, relatives and carers. There is also a carers' information sheet which is used to help provide some basic information about the patient prior to admission.

We noted that some patients had access to the advocacy service and some did not, however, on review, the patients who did not were new admissions to the ward. We highlighted to staff on the day that all patients should have access to advocacy services.

We noted that interpreter services were readily available should they be required.

Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. 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 there were two people who were restricted in the use of telephones. All appropriate paperwork was in place and available.

The specified persons good practice guidance is available on our website at:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s274 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 see any advance statements in the paper files, or recorded on EMIS. We discussed this with the staff on our visit and we heard that as the ward is for acute adult admissions, where patient's mental state may affect their engagement in developing an advance statement. Staff were asked to highlight the value of advance statements to patients when discharge was being considered.

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

We were aware that during the pandemic, restrictions had to be put in place. This meant that various activities out with the ward had to be put on hold, and that some of the patient group had struggled with this change to their routine. However, we heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients. There were mixed views from patients we spoke to about the level of activity in the ward. One patient commented that it was good and you could participate if you wished, another patient said there was "nothing to do" but was happy with that.

The physical environment

The layout of the ward consists of 20 single en-suite rooms. There is a lounge area and a separate dining area for the patients, both are bright and spacious. The environment was good and we were able to see where there are plans to introduce more activity into the patient's day. Some gym equipment had been sourced and a room identified. The staff expected this to be in use by the patients in the very near future. We were told that an application for monies has been made to Glasgow City Council endowments team by the physiotherapy team lead, to purchase further pieces of exercise equipment for Rutherford Ward; the aim being to improve engagement in physical activity, as motivation and maintenance of a physical activity programme. It is hoped that a decision on this is imminent. There was easy access to outside space around the ward and we could see patients using this whilst on our visit. An area of concern is that the garden area is not secure and we were told that there are plans to put a fence up round the garden area to make it more private, but also more secure for patients.

Patients have a right to feel safe whilst in hospital and the lack of appropriate fencing meant that they could be open to unwanted intrusions from the surrounding areas.

Recommendation 3:
Managers should provide appropriate security for patients in their care, in this case by erecting appropriate fencing to prevent intrusion of the garden area from others.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plans and reviews to ensure they fully reflect the patients' progress towards stated care goals and recovery and that recording of reviews are consistent across all care plans.

Recommendation 2:
Managers should ensure that there is a clear record of the attendance at the MDT, the decisions made and who will be responsible for updating the patient and/or their relatives and carers if they had not been in attendance.

Recommendation 3:
Managers should provide appropriate security for patients in their care, in this case by erecting appropriate fencing to prevent intrusion of the garden area from others.

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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