Mental Welfare Commission for Scotland

Report on announced visit to: Gartnavel Royal Hospital, Henderson Ward, 1055 Great Western Road, Glasgow G12 0XH

Date of visit: 25 January 2023

Where we visited

Due to the Covid-19 pandemic, the Commission adapted 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. This local visit was carried out face-to-face.

Henderson Ward is a 20-bedded, single room unit with en-suite facilities. The ward is an acute adult assessment unit with male and female patients. On the day of our visit there were no vacant beds. There was one delayed discharge on the ward but this patient was discharging in the next few days. We last visited this service on 15 August 2019 and made no recommendations.

On the day of this visit we wanted to hear how patients and staff have managed during and following the pandemic.

Who we met with

We met with, and reviewed the care of nine patients, seven who we met with in person and two who we reviewed the care notes of. On this visit we did not meet with any relatives.

We spoke with the senior charge nurse, the charge nurse and other staff on duty.

Commission visitors

Anne Craig, social work officer

Justin McNicholl, social work officer

Susan Hynes, nursing 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 spoken with knew the patient group well. It was good to note that the patients we met with highly praised the staff, one patient commented “they are angels in blue”.

Almost without exception all the patients we spoke with praised the staff highly and one patient commented that the staff were “brilliant” and “always there for you”. We heard, “Even if they are very busy they will always come back to you”. Another said “they sit with me, they talk to me to see what would help me at the time”. “It’s a busy ward and there’s never enough staff”. Another said they felt safe because “they know what they are doing”. Another patient said “staff are fantastic, they never get a break as the buzzers go all the time”.

We were told that staffing was and is exceptionally difficult at times, mainly due to vacancies and annual leave and there was notable shortages of qualified and non-qualified on every shift. Although this is improving there are high numbers of bank and agency staff on each shift. Across all our interactions with patients it was clear that patients felt safe and secure when there were permanent staff on shift or regular bank staff. Some commented they felt less safe when bank/agency staff were on duty as they felt that their commitment to the patients was not as strong as the permanent staff.

On the day of our visit, there were three patients subject to enhanced observations on the ward; this had increased to four by the end of the visit. Continuous interventions through enhanced observation continues to have a significant impact on the day’s staffing levels and reduces the time staff can spend with the other patients. A further impact of shortages in staffing was the ability to support patients with on time off ward if they require to be accompanied.

We found that there was strong leadership and teamwork on Henderson Ward. We spent some time speaking with the senior charge nurse about the running of the ward and their vision for how the ward should operate. We also spoke with the charge nurse who commented positively about the leadership on the ward.

Care plans

On review of the care plans, we saw a number of person-centred care plans, although there was limited detail recorded in the participation with patients or with one-to-one time with staff. It was unclear if care plans were reviewed and this should be specifically evidenced in the care plans/care records.

We did not find consistent evidence of one-to-one discussion with nurses and the patients, although this was clearly happening due to the in-depth knowledge staff provided about the patients and what we heard from feedback from the patients themselves.

We were aware that with the service as a whole, improvements to care plans and reviews were being developed and we suggested using the Commission guidance on our website to help in the process. 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 regularly audit care plans to ensure they are person-centred; include all the individual's needs; ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 2:
Managers should ensure all one-to-one sessions between a patient and nurse are clearly documented in the care records.

We saw that physical health care needs were being addressed and followed up appropriately by referrals to other services as required.

There were patients on the ward whose first language is not English. We enquired if patients had been given information in their own language, we were advised that they had and they also had access to interpreter services and we noted an interpreter attended the MDT for a patient to translate.

Care records

Information on patients care and treatment is held in two ways, there is a paper file and the electronic record system EMIS. We discussed this on the day of the visit and were assured that discussions are ongoing with the IT department to ensure that going forward most information will be recorded on the EMIS system. Daily care records were detailed, structured and written in a timely manner.

We found clear risk assessments which were also detailed and timely. We asked for a distinction in the care records that clearly indicated between one-to-one sessions and progress notes.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, speech and language therapy staff and psychology staff. Referrals can be made to all other services as and when required.

It was clear from the mostly detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and give an update on their views. This also included the patient and their families should they wish to attend. It was clear to see from these notes that when the patient was moving towards discharge that community services also attended the meetings.

We heard that meetings had been held online during the restrictions had enabled more professionals to attend. Continuing to hold these meetings in this way has been embedded and was welcomed. Family members who wished to attend, but who were not keen on using the online facility continued to be given the opportunity to attend in person.

Use of mental health and incapacity legislation

On the day of our visit, 12 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.

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 T3s had been completed by the responsible medical officer to record non-consent; they were also 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. There were no patients with named persons on the ward during our visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. There were no patients on the ward requiring treatment under S47 of the Adults with Incapacity Act 2000.

Rights and restrictions

Henderson Ward continues to operate a locked door with a keypad and this is commensurate with the level of risk identified with the patient group. However, the access number was clearly visible above the keypad.

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 specified persons on the ward and all paperwork was in place, including reasoned opinions.

Our specified persons good practice guidance is available on our website:
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 s276 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 advance statements on record for any of the patients during our visit and we encouraged staff to discuss the making of an advance statement as a patient progressed towards discharge and their mental health had improved.

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

The ward benefits from their own dedicated patient activity co-ordinator (PAC). Several patients commented on the PAC and this member of staff is clearly very well thought of. On the day of our visit, Therapet had visited the ward, which was well received by many of the patients. There were also plans for a Burns Night. One patient commented that they particularly enjoyed movie nights and karaoke. Another patient commented that they did every activity that was offered as it provided respite from the symptoms of their mental disorder.

The physical environment

The layout of the ward consists of 20 single rooms with en-suite facilities. One room is slightly larger and can accommodate patients who have physical disability and there is an assisted bathroom. There are several lounge areas which can be utilised by the patients as they wish, with some quieter areas and some larger, where TV and games are available.

There is a large separate dining area for the patients. The ward is bright, spacious and welcoming with high windows. The environment was immaculate and we were able to see where efforts have been made to soften the public rooms. One patient commented on the ward domestic and told us that they were fastidious in keeping the ward clean.

Patients have access to a large garden area which is shared with other wards. It is well kept, and patients have, and do help with the maintenance of the garden area.

Summary of recommendations

Recommendation 1:
Managers should regularly audit care plans to ensure they are person-centred; include all the individual's needs; ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 2:
Managers should ensure all one-to-one sessions between a patient and nurse are clearly documented in the care records.

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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