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: 15 February 2023

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.

Tate Ward is a 20-bedded, adult mixed-sex ward, based in Gartnavel Royal Hospital. The ward provides assessment and treatment for adults who have a mental illness. On the day of our visit there were no vacant beds.

We last visited this service on 18 May 2021 and made recommendations about reviewing and auditing care plans, and recording contact between patients and nursing to reflect the patients' presentation. We had also recommended that there should be regular audits of progress notes and there should be a structured and meaningful activity timetable for the patients.

The response we received from the service was that changes had been implemented, and hat these continued to be monitored and audited; improvements had been made in recording and identifying any inconsistencies. There was a recommendation that had not been actioned which required a dedicated activities co-ordinator.

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

Who we met with

We met with, and reviewed the care of eight patients, four who we met with in person and four who we reviewed the care notes of. We did not meet or speak with any relatives.

We spoke with the senior charge nurse, the charge nurse, the hospital manager, the physiotherapy team lead and the occupational therapy team lead.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

All the patients we spoke with praised the nursing staff highly and one patient commented that the staff were "all great, fantastic, absolutely no complaints". Another patient discussed her relationship with her responsible medical officer (RMO) and said that they were "brilliant" and had a "great relationship". Another patient told us "the nursing team are great".

Throughout the visit, we saw kind and caring interactions between staff and patients. Staff spoken with knew the patient group well. The patients we met with highly praised the staff, one patient commented "everyone is really approachable".

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, one is still available for patients if they require to use it.

When we last visited the service we found examples of care plans that lacked reflection on the care and treatment being provided for patients. On this occasions we felt that although there had been an improvement, details in the care plans were inconsistent. Some care plans were excellent, others were brief in detail. We discussed this with the senior charge nurse who acknowledged that this is an area of concern and plans were in place to support staff to make the care plans more meaningful and person-centred. We saw that physical health care needs were being addressed and followed up appropriately. We were unable to locate robust reviews that targeted nursing intervention and individuals' progress and we think that care plans should reflect individual needs and associated risks.

There was a clear awareness of reviews happening but this was not reflected in the paperwork. We were aware that in the service as a whole, care plans and reviews are being worked on and we suggested using the Commission guidance on our website to help in the process. We recommend that an audit of the care plan reviews is carried out to ensure that they reflect the work being done with individuals towards their care 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 regularly audit care plans to ensure they are person-centred; that they include all the individual's needs; they should ensure individuals participate in the care planning process and are given opportunities to engage in meaningful care plan reviews.

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 that are either based in the unit or accessible to the service. Referrals can be made to all other services as and when required.

The detailed MDT meeting notes highlighted that everyone involved in an individual's care and treatment was invited to attend the meetings and update on their views. This also included the patient and their families should they have wished 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. The ward occasionally has patients who are boarding from their home ward. At the time of our visit, there were three patients from other areas and whilst not ideal, it did not detract from the care and support given by the nursing team or the dedicated responsible medical officer.

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend; meetings have continued to be held this way post-pandemic. We were assured that family members wishing to attend, but not keen on using the online facility, continue to be given the opportunity to attend in person.

We heard that at the moment, whilst there is a national shortage of appropriately trained nursing staff and there are a high number of inexperienced staff across all wards, Tate Ward is currently fully staffed. With the acuity of patient's symptoms requiring increased staff input, it was noted that whilst training opportunities for staff are more readily available, the ability to have staff released to training has been a challenge.

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. We found there to be a good standard of daily care records, which were detailed, structured and written in a timely manner. We found up-to-date risk assessments that were also detailed. The senior charge nurse advised that Tate Ward had been a test ward that had uploaded and implemented other paper-based records.

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'). Most of 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 where they did not this was as a result of poor mental health.

All documentation pertaining to the Mental Health Act and 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, with the exception of two cases that we found needed updated in relation to as required medication. We brought this to the attention of the senior charge nurse on the day of our visit.

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 and recorded non-consent; 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. We did not find any patients who had a named person.

Recommendation 2:
Managers should ensure prescriptions of as required medication are recorded and specific dosages, with frequency of administration and daily maximum dose made clear. This is necessary for safe prescribing.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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. We noted that there was one patient who required a section 47 certificate; this had been in place but had expired. We brought this to the attention of the senior charge nurse as well.

Rights and restrictions

Tate Ward operates a locked door, commensurate with the level of risk identified in the patient group. Although the number is not displayed for exit and/or entry, staff provided the code to patients who needed to use it. Due to the location of the ward on the Gartnavel Royal Hospital site, there was a clear rationale for maintaining a locked door.

We noted leaflets were available for patients and visitors, which included a relatives' questionnaire and some information about the ward. There were several notice boards with a range of information, including patients' rights, advocacy and comments relating to "you said/we did".

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 provides 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 was one specified person.

Our 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 sections 274 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 find advance statements for any patients on the ward.

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, the restrictions that had been put in place meant that various activities out with the unit were put on hold and some of the patient group had struggled with this change to their routine. While we heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients, several patients told us that they felt there was not enough to occupy them on the ward. This was a recommendation on our last visit and it is disappointing to see that there has been no progress in securing, either a patient activity co-ordinator or a therapeutic activity nurse. We spoke with the hospital manager who explained that the Gartnavel Royal Hospital does not have a funded patient activity model. This is unique to Gartnavel Royal Hospital site, as other similar hospital admission units in other parts of the Greater Glasgow and Clyde area have had this model for a number of years.

We feel that this is discriminatory to patients on this site and specifically for those in Tate Ward; it is likely that when or if an activity co-ordinator is appointed this would reduce the nursing complement for the ward.

We spoke with the physiotherapy team lead about how they has been able to appoint a band 3 technician who is also a personal trainer. This innovative approach has supported patients with structured activity, usually in the gym area. However, activity in the ward on an ongoing basis continues to be a concern. The nursing team tried to engage patients in meaningful activity as much as possible and we saw evidence of staff and patients enjoying some time together in one of the lounge areas. We noted there was an activity timetable displayed in the dining room, as well as posters advertising group sessions, such as lunch group and gardening group. We were told these were not yet up and running but was hoped that this would be imminent, especially with the gardening group as the weather improves.

Recommendation 3:
Managers should ensure a structured activity timetable is available for all patients. Patients who have restrictions placed upon them and are unable to attend activity out with the ward should be provided with activities based upon their area of interest or need.

The physical environment

The layout of the ward consisted of 20 single rooms, all en-suite. There were several lounge/quiet areas on the ward for patients. A separate dining area for the patients was bright and spacious. The environment was immaculate and we were able to see where efforts had been made to soften the public rooms.

Tate Ward was built as a long stay ward for older adults and has been significantly modified/modernised to accommodate acute adult admission patients. We were concerned to note that there were several areas in the ward where there was no clear line of sight, and there were two areas in particular which we discussed with the senior charge nurse. We heard

that they had regularly brought these areas to the attention of hospital managers and the health and safety team, as there was a safety risk for patients and staff. The senior charge nurse had offered solutions, including installation of a convex mirror on the wall and a reconfiguration of some of the non-clinical areas that offered some options for consideration.

We also noted that because of the location of Tate Ward, the bedrooms and some communal areas faced on to a public right of way through the hospital grounds. None of the windows had any mesh over them and there were safety concerns around this. The rooms that faced on to the road could compromise the privacy of the patients while they were resting in their rooms.

Tate Ward has ready access to the garden area and we heard how staff had used their own time to make the outdoor area more welcoming and attractive to sit in. One of the nurses was a keen gardener and there were plans to plant up the outside area with help from the patients when the weather improves. We heard how access to the garden from the ward really helped patients who were experiencing stress and distressed behaviours. We considered that it is important for patients to have access to safe and pleasant outdoor space.

Recommendation 4:
Managers should consider installing equipment to minimise any blind spots and consider reconfiguration and additional security measures of the non-clinical areas to ensure appropriate safety and security of the patients and staff.

Recommendation 5:
Managers should undertake a review of the windows in Tate Ward to ensure the safety, security and privacy for the patients and staff.

Summary of recommendations

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

Recommendation 2:
Managers should ensure prescriptions of as required medication are recorded and specific dosages, with frequency of administration and daily maximum dose made clear. This is necessary for safe prescribing.

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Recommendation 5:
Managers should undertake a review of the windows in Tate Ward to ensure the safety, security and privacy for the patients and staff.

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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