Mental Welfare Commission for Scotland

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

Date of visit: 15 April 2024

Where we visited

Henderson Ward is a 20-bedded, adult acute mental health admission ward, situated in the grounds of Gartnavel Royal Hospital, in NHS Greater Glasgow and Clyde (NHS GGC). On the day of our visit, there were 20 individuals on the ward and no vacant beds.

We last visited this service in January 2023 as an announced visit and made recommendations on nursing care plans and the recording of the nursing one-to-one sessions.

On the day of the visit, we wanted to follow up on the previous recommendations and meet with individuals in the ward.

Who we met with

We met with six individuals and reviewed their care records. As this was an unannounced visit to the service and the ward had no prior warning of the visit, relatives were not informed of the visit. Therefore, we were unable to meet with any relatives on the day of the visit.

We spoke with the service manager, operational manager, the senior charge nurse (SCN), and several members of the nursing team.

Commission visitors.

Mary Leroy, nursing officer

Douglas Seath, nursing officer

Paul Macquire, nursing officer

What people told us and what we found

Henderson Ward benefits from good leadership, and has developed clear processes that enable consistent, and well-defined nursing processes that work well with the demands often found in an adult acute mental health service.

Nursing staff appeared motivated and reported enjoying working in the ward. They were able to knowledgably answer all queries that we had on the day and were aware of the importance and opportunities for supporting patients' rights.

We did hear that there had been a high turnover in nursing staff recently, with a number of "newly qualified staff moving on." The SCN and senior team are reviewing and planning to develop their protocols on how to best support newly qualified staff; they are giving consideration to reflection/supervision sessions, training opportunities as well as reviewing the input and information provided from previous newly qualified staff.

We were told that the service had significantly reduced the use of agency nursing staff and increased new staff to the team. The SCN commented that the situation regarding staffing was more stable now.

We discussed with the SCN the issue of ward capacity and individuals who were boarded out from the ward. There were 14 patients who were boarded out to other wards. We were told that the ward often operates at capacity, and for individuals and staff this can be challenging.

Recommendation 1:
Managers must ensure that the boarding out protocol clearly defines when an individual should no longer be classed as a boarder, as well as what attempts should be made to move them to their regular ward and must ensure every boarder experiences continuity of care commensurate with being in their regular ward.

Individuals we met with on the day provided feedback on the service; for most individuals the feedback was positive. The staff were described as "amazing"," brilliant", "approachable", and "very caring", with one person commenting " this is the best place for me right now, I feel safe". Another person commented on feeling "really involved in my care."

However, we did hear from one individual that they found that on days where there were "unfamiliar staff" on duty, (bank or agency staff), that this could be challenging.

For individuals who reflected on feeling involved in their care and treatment, they were able to discuss their outcomes and goals, the experience of their admission to hospital, and how they were working toward recovery with this as a shared experience between the clinical team and themselves.

The team had a number of processes that augmented effective communication with carers and relatives. Contact with relatives was recorded in the care records, and staff spoke of their overall commitment to involving carers and relatives in assessment and care planning where consent had been given. Families and carers were invited to the MDT meeting, when appropriate.

Care, treatment, support, and participation.

Individuals admitted to Henderson Ward required assessments based upon their mental health, their physical wellbeing, and in relation to any risks. All the assessments we reviewed were comprehensive and person-centred. From initial assessments, we found these were reviewed and updated, reflecting the individual's journey to recovery. On our previous visit to the service, we made a recommendation regarding nursing care plans; we were pleased to see the improvements in all aspects of care planning.

Similar to the assessments, we found the nursing care plans were holistic and person-centred with a clear focus on both mental and physical health. They were of a good standard and several had evidence of an individual's participation in the process of identifying needs, goals, and interventions to aid recovery.

For one person, we did note, and commented on the day, that there appeared to only be one care plan, and that this was static and had not been reviewed or updated. The SCN addressed this on the day.

We found the nursing care plan reviews to be meaningful and they targeted nursing interventions and patient progress, linking this clearly with the care goals.

The individuals we met with on the day were able to comment on their care plans, their care and treatment, where they were on their recovery journey and when appropriate future plans regarding their discharge. On the day of our visit there were no delayed discharges from the service.

In the risk assessments and the supporting management plans, there was a clear chronology of significant events during the patient's journey to recovery. The records were easy to access, and risk management plans were integrated into the individual's care plans.

Each individual's chronological notes provided detail as to how the individual presented on a day-to-day basis and had evidence of the person's participation in a varied programme of activities that were provided in the ward. We noted there was good information about days when individuals needed higher levels of support.

On our last visit, we had made a recommendation about the documentation of one-to-one sessions with nursing staff. We were pleased to find well- documented evidence of one-to-one nursing interventions in the chronological notes during this visit.

Care records

Individual records are held on EMIS, the electronic health record management system used by NHS GGC. Additional documents continue to be collated in paper files, including nursing care plans. There is a long-term plan in NHS GGC for all records to be held on EMIS, but no further information at this time as to how this will be implemented in the ward, and how staff and individuals will be required to adjust to this transition.

We found all records on the electronic and paper systems were up-to-date and easy to navigate. When examining the records, we found that the alert system on EMIS was used to

make staff aware of any risks, which included medication reactions, considerations around physical health and individuals' risks to themselves or others.

Multidisciplinary team (MDT)

The ward has a multidisciplinary team (MDT) on site consisting of five psychiatrists, nurses, a patient activity nurse, psychology, dietetics, occupational therapy, pharmacy, and social work. Referrals could be made to all services as and when required.

The MDT meetings are held twice weekly to review the care and treatment for individuals.

Most patients we met with told us that they were invited to attend the MDT meeting. We also heard that prior to the meeting, individuals are invited to record their views on a pre-meet document, that gave them the opportunity to participate in their care, discuss their progress and participate in the meeting, ensuring that their views were put forward prior to the meeting.

We were pleased to see that the weekly MDT meeting notes were detailed and included updates from all professionals. The template also ensured that the actions and outcomes were also clearly identified.

Use of mental health and incapacity legislation

On the day of the visit, 13 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3s) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

On reviewing the T2 certificates, for two individuals, the information on the certificates related to the individual's mental health presentation, and the drug class, however the specific medication was not named, for example "antidepressant to regulate mood". The medication being administrated was therefore not legally authorised. We raised this with the SCN on the day of our visit, and advised that as a matter of urgency, the certificates should be reviewed and updated by the respective responsible medical officers (RMOs). We will follow up these issues with regards to each individual's treatment with the respective RMOs.

Recommendation 2:

Managers should ensure the review and audit of medication records for individuals requiring T2 and T3 certificates, and ensure that all treatment certificates are current, and all prescribed medication/treatment is legally authorised.

Any individual who receives treatment under the Mental Health Act can chose someone to help protect their interests, that person is called a named person. Where an individual had a nominated named person, we found copies of this in the file.

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 (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. The doctor must also consult with any

appointed legal proxy decision maker and record this on the form. We found s47 certificates for all the patients that we reviewed, and where a proxy decision maker was appointed, they had been consulted.

Rights and restrictions

Henderson Ward continues to operate a locked door, commensurate with the level of risk identified with the patient group. There was a locked door policy in place and it was available to all visitors on entering the ward.

Individuals that we met with during our visit, and who were subject to detention under the Mental Health Act, had a good understanding of their detained status. For one individual who was receiving their care informally, the patient was less clear as to whether they were subject to any restrictions. An example of this was when an individual wanted to have time off the ward and there was a need for staff to escort them. We discussed this on the day as we considered it an example of the ward's requirement to ensure that all individuals, whether they were subject to legislation or receiving their care and treatment informally, needed to understand their rights, what restrictions were put in place that may have an impact upon them, and the reason for this.

On the day of the visit, there were three individuals who required to have enhanced input through continuous intervention. We discussed with both the SCN and senior managers the significant impact this had on daily staffing. Again, at the end of day meeting there was a fuller discussion on that the level of enhanced input through continuous intervention that created a challenge for all the adult acute wards in the service.

We did not see any advance statements on file for those individuals that we reviewed. We encourage staff to discuss the making of an advance statement, as individuals progress towards discharge and their mental health has improved. We also discussed with senior managers how the role of the community mental health teams could support in this aspect of care.

All individuals admitted to Henderson Ward have the right to advocacy services. This service was available, and we noted a poster displayed in the ward with relevant contact details; some of those that we met with told us that advocacy input was highly valued.

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.

Activity and occupation

Henderson Ward benefitted from having their own dedicated patient activity nurse (PAC). We heard from people that they enjoyed a range of recreational and occupational therapies. The weekly activity planner offered opportunities for relaxation sessions, health and wellbeing, walking, badminton, newspaper discussion, bingo, quizzes, and arts and crafts.

Most of the patients we met with commented positively on the activities that are available on the ward. Many spoke about the walking and gardening groups, art and crafts, games, and the

recent addition of a projector for movie nights. We heard that the PAC nurse could provide activities in the evenings and at weekends.

We were also told about the value of the voluntary services coordinator and the activities that they arranged on the ward; the therapet, and musical events activities were particularly appreciated.

The physical environment

The ward is bright and spacious, and there are high windows in the corridor that ensure natural light. The ward was clean, well decorated and maintained. There is also access to a well-planted enclosed garden.

The entrance corridor leading into the ward is a warm and welcoming introduction to the ward, with artwork on display in the corridor.

There are 20 single rooms with en-suite facilities. There is one slightly larger room designed to accommodate an individual with a physical disability, as well as assisted bathroom. There are several seating areas that can be used, and a therapeutic activity room in the ward. There is also a large dining area.

Summary of recommendations

Recommendation 1:
Managers must ensure that the boarding out protocol clearly defines when an individual should no longer be classed as a boarder as well as what attempts should be made to move them to their regular ward and must ensure every boarder experiences continuity of care commensurate with being in their regular ward.

Recommendation 2:
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Service response to recommendations.

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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.

Contact details.

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