



Mental Welfare Commission for Scotland

Report on announced visit to: Rutherford Ward, Gartnavel
Royal Hospital, 1053 Great Western Road, Glasgow G12OYN

Date of visit: 12 July 2018

Where we visited

Rutherford Ward is a 20-bedded adult acute mental health mixed-sex ward. The ward is based in Gartnavel Royal Hospital. We last visited this service in September 2017 and made recommendations regarding mental health legislation, rights and restrictions, and the provision of evening and weekend activities.

On the day of this visit we wanted to follow up on the previous recommendations and also look at physical health care provision, activities, and patient participation in their care.

These themes were identified from our adult acute themed visit report as activities that services across Scotland may need to improve.

Who we met with

We met with and reviewed the care and treatment of six patients.

We spoke with the senior nurse manager (SCN) who has recently commenced his role on this ward. We also spoke with other members of the ward team.

Commission visitors

Mary Leroy, Nursing Officer and visit coordinator

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit we were able to meet with six patients. There was a calm atmosphere in the ward. All the interactions towards patients we observed from staff were friendly and supportive. Staff were knowledgeable about patients when we discussed their care. We heard positive comments about staff from some patients we met.

We reviewed care plans. Some were person-centred containing individualised information identifying clear interventions and care goals. However, there were also some care plans that were not person-centred and did not reflect the specific care needs of the individual.

We were informed that risk assessments were reviewed on a regular basis, this was either daily or weekly by the key nurse and through the multidisciplinary team (MDT) meeting. On review of this documentation we were concerned that where some patients had a complex history of risk, the risk assessment and care plans did not reflect this information. We raised this matter with the SCN on the day of our visit.

Recommendation 1:

Managers should ensure that all care plans and risk assessments are person-centred, contain individualised information reflecting the care needs of each person, and identify clear interventions and care goals.

We saw good attention to physical healthcare needs, including a full medical assessment on admission to the ward with routine physical health monitoring and referral to specialist services if required. The SCN also informed us of a health promotion project that will combine healthy eating and exercise. This will be delivered jointly by the physiotherapist and dietician. We look forward to hearing more about this project on our next visit to the service.

There is pharmacy input into the ward, with regular pharmacy involvement in the multidisciplinary reviews.

We found evidence of patient participation, with patients attending their weekly MDT meeting and patients' views regarding their care and treatment being taken into account.

The record from the MDT meetings were detailed and listed all those present. Communication with families was evident from a communication sheet in the files with details of contact and conversations. The work in this area stems from a greater awareness of the 'triangle of care' initiative.

Use of mental health and incapacity legislation

On the day of our visit six of the patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and copies of the certificates authorising detention were in the patient's notes. Further information about legal status was clearly recorded in the care plan documentation.

Consent to treatment certificates (T2) and certificates authorising treatment (T3) forms under the Act were in place where required.

On reviewing those forms we noted that, for one patient there were medications prescribed that we would have expected to have been authorised on a (T3) certificate. This was raised on the day with the SCN with the expectation that this would be addressed.

Rights and restrictions

Patients in the ward have access to independent advocacy services and some patients told us about the support they had received.

Patients we spoke to were clear about their legal status as were the staff. Informal patients knew they could leave the ward if they so wished. There was written

information available for patients in relation to their rights for both detained and informal patients.

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/rights-in-mind/>

Activity and occupation

On the day of the visit ward activities were taking place with some activities recorded in notes along with one-to-one nursing sessions.

Options for activities were provided on the ward by occupational therapy staff and patient activity coordinator (PAC) nurse. Some patients reported attending artwork and crafts, walking, and breakfast and lunch groups.

We spoke with the PAC nurse who provides a programme of activities for the ward three days a week, at the weekend or through the week. She states that the service used to have a full time PAC nurse (covering five days) for the ward, but that this is now reduced to three days a week. Due to the demands of the service she may be asked to cover other clinical duties. If this is happening on a regular basis this could have a detrimental effect on access to therapeutic and social activities.

The physical environment

Rutherford Ward is relatively new and all patients have en-suite single rooms. The ward is bright and airy and has some artwork on display. The ward has easy access to the garden areas—but the fact that the gardens are not enclosed can present difficulties in observation of some patients.

Summary of recommendations

1. Managers should ensure that all care plans and risk assessments are person centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals

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.

Mike Diamond
Executive Director (Social Work)

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 MWC 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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