

Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 16 July 2019

Where we visited

Tate Ward is a 20-bedded adult acute mixed-sex ward. The ward is based in Gartnavel Hospital. We last visited this service on 30 April 2018, and made four recommendations regarding nursing care plans and restrictions placed on patients leaving the ward.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and also look at paperwork relating to treatment under part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003, specifically consent to treatment certificate (T2).

We were also keen to see whether evidence of activities and attendance to the local activity Hub had improved. We were told during our last visit that patients may be less likely to engage in the Hub's therapeutic activities due to the distance between Tate Ward and the Hub. The distance is approximately a 15-minute walk and we were told patients are having to travel by taxi from the ward to the Hub.

Who we met with

We met with and or reviewed the care and treatment of six patients. On this visit we did not meet with any carers or relatives. We advised the nurse in charge to inform carers and relatives of our visit and we would welcome contact from carers and relatives should they wish to speak to us following our recent visit to Tate Ward.

We spoke with the senior charge nurse (SCN) and other members of the clinical team. We were told there are currently two vacancies for charge nurse posts. While this is not ideal we were told there are plans to recruit into these posts, and we look forward to meeting the new senior nurses during our next visit to Tate Ward.

Commission visitors

Anne Buchanan, nursing officer

Mary Leroy, nursing 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. They told us staff were approachable, engaged well and have a positive attitude. Staff were knowledgeable about the patients when we discussed their care. We saw evidence of patient-centred care plans which included participation from patients.

A number of patients' care plans included individuals' strengths, clear, recovery-focussed detail, and meaningful reviews. However, not all care plans nor reviews were consistent. There were a number of care plans which had not been updated to reflect individual patients' changes in presentation, or evidence of recovery. Care plans which related to plans for discharge from hospital back to the community had not been updated for a considerable length of time, therefore it was difficult to have a sense of whether the discharge was in fact achievable, or whether plans would need to be reconsidered.

Recommendation 1

Managers should ensure all care plans are person-centred, contain information reflecting the care needs of the individual patient, and identify clear interventions and care goals. Managers should consider regular audits to assist with promoting a consistent approach to care planning.

There were comprehensive admission risk assessments carried out by nursing and medical staff. Physical health assessments are also carried out as part of the admission process. There was evidence of excellent physical health screening including an assertive approach to smoking cessation with a high percentage of patients offered Nicotine Replacement Therapy at the point of admission to the ward. Patients who are considering stopping smoking are referred to the smoking cessation service for additional support.

Patient care is reviewed at a weekly multidisciplinary team (MDT) meeting. There was evidence of input from medical, nursing, allied health professionals, pharmacist, community mental health services and social workers. We were told carers and relatives are invited to attend MDT meetings to discuss patients' care, treatment and progress in the ward.

We saw evidence of input from psychology. Psychological formulations are undertaken with outcomes shared with the MDT. Psychological formulations are helpful for the patients and staff as they provide an understanding of presentation and behaviours. Furthermore, we saw evidence of excellent assessments carried out by occupational therapists. With evidence from those assessments OT care plans were detailed which included the patients' strengths and with a focus on recovery based interventions.

Recommendation 2

Managers should ensure psychological formulations undertaken by psychology and assessments by occupational therapy are integrated into patients' care plans.

There are currently two systems for recording documentation. EMIS records chronological and MDT documentation electronically with all other notes held on paper file. While this is not ideal we were told EMIS will in the future be able to accommodate all information relating to

patients' care and treatment. We welcomed this recent update and hope to see fully integrated records soon.

We would like to draw attention to the transfer of patients between inpatient wards. The use of 'stable patient transfer' was discussed with the senior charge nurse on the day of our visit. Patients who are considered to be not acutely unwell are highlighted as being able to be transferred to another ward, to make way for admissions. While we appreciate there are ongoing issues with inpatient capacity for admissions to hospital we do not consider transferring patients between wards as an appropriate approach to managing this situation. We were told neither patients, their relatives, nor nursing staff find the 'stable patient transfer' model acceptable largely because of the potential for patients care pathway to be compromised thus leading to patient's recovery being undermined.

Use of mental health and incapacity legislation

On the day of our visit, 13 patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act); of those patients subject to compulsory treatment, we reviewed the legal documentation available within their file. Paperwork relating to treatment under part 16 of the 2003 Act was mostly in good order.

Rights and restrictions

On the day of our visit there were two patients on an enhanced level of observation. Patients who require this level of observation are reviewed daily by the clinical team to determine whether this level of observation is required. While decisions relating to level of observations are largely determined by the clinical team, senior nurses are given authority to reduce levels of observation, thus reducing the risk of patients remaining on enhanced level of observation unnecessarily.

On our last visit we were concerned patients who were not subject to the MHA (2003) were having time out of the ward restricted, with no evidence of any collaborative approach to gain their consent to this restriction. We were pleased to see on this visit patients were given unrestricted access to and from the ward.

We were told independent advocacy is available for patients, initial contact is made by telephone and staff can assist patients to do this. Furthermore, legal representation is available to all patients who request it. Again, nursing staff have contact details for patients who require assistance.

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.mwscot.org.uk/law-and-rights/rights-mind>

Specified persons

S281 to 286 of the MHA provide a framework within which restrictions can be placed on people who are subject to detention in hospital. Where a patient is a specified person in relation to these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied.

The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed. We found one patient who was a specified person was due to be discharged from hospital. We expect to find evidence of a review prior to discharge and specific restrictions relating to this patient revoked. Our specified persons good practice guidance is available on our website:

<https://www.mwcscot.org.uk/sites/default/files/2019-06/mhc-guides-specifiedpersons-revised.pdf>

Activity and occupation

We were told patients have the opportunity to engage with activities which are based on the ward. Nursing and OT staff undertake some art and recreational activities. Recently funding for a gardener to work with patients has been secured. We welcomed this news as patients we spoke with enjoyed time spent outdoors.

We are concerned patients continue to engage less with the local activity hub based within the main hospital. We were told patients travel to and from the hub by taxi as it is approximately a 15-minute walk. Patients who have mobility problems are less likely to access the hub therefore opportunities to engage in therapeutic activities are limited.

We are concerned patients in Tate Ward are disadvantaged due to the proximity of the ward to the Hub therefore activities which are known to have beneficial results are not available to patients in Tate Ward. We discussed this on the day of our visit with senior nursing staff, and while we appreciate some patients have mobility problems, patients could be encouraged to walk to the hub as part of their therapeutic activity care plan. We were told Tate Ward does not have a Patient Activity Co-ordinator nor a Therapeutic Activity Nurse. We discussed the advantages of having a PAC or TAN, as this could possibly benefit Tate Ward patients who were unable to attend therapeutic activities in the Hub.

Recommendation 3

Managers should ensure that therapeutic activity participation is encouraged and where a patient is unable to attend activities out with the ward alternative arrangements can be made.

Recommendation 4

Managers should ensure a structured activity timetable with activities available on both weekdays and weekends is in place.

The physical environment

We were told all 'snagging' issues raised by staff on our last visit have now been attended to. Patients told us they were happy to have en-suite bedrooms, quiet areas, access to a secure garden and a dining area and kitchen. However, we were told the ward does not have its own laundry for patients to wash their own clothes. We were told patients would prefer to have access to washing machines and driers.

Summary of recommendations

Recommendation 1

Managers should ensure care plans are person-centred, contain information reflecting the care needs of the individual patient, and identify clear interventions and care goals. Managers should consider regular audits to assist with promoting a consistent approach to care planning.

Recommendation 2

Managers should ensure psychological formulations undertaken by psychology and assessments by occupational therapy are integrated into patient's care plans.

Recommendation 3

Managers should ensure that therapeutic activity participation is encouraged, where a patient is unable to attend activities out with the ward alternative arrangements can be made.

Recommendation 4

All patients should be provided with a structured activity timetable. Activities available for each day, 7 days per week should be clearly identified for patients to view on the ward.

Good practice

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/ ALISON THOMSON

Executive Director (Social Work/ 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 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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