Mental Welfare Commission for Scotland

Report on announced visit to:

Rutherford and McNair wards, Gartnavel Hospital, 1053 Great Western Road, Glasgow, G12 0YN.

Date of visit: 29 August 2023

Where we visited

Rutherford and McNair wards are 20-bedded, mixed-sex, adult acute mental health admission wards, situated in the grounds of Gartnavel Hospital. On the day of our visit there were no vacant beds.

We last visited McNair ward in September 2022 and Rutherford ward in October 2022. Following those visits, we made recommendations for McNair ward on care planning and one-to-one meetings. For Rutherford ward, the recommendations focussed on care planning, the multidisciplinary team meeting (MDT), and the environment.

Who we met with

In Rutherford ward we met with and reviewed the care of six patients and reviewed the notes of a further four patients. We also met with one relative.

In McNair ward we met six patients in person and reviewed their care notes. We also met with one relative.

We spoke with the service manager, the senior charge nurses, consultant psychiatrist, and several members of the nursing team.

Commission Visitors

Mary Leroy, nursing officer

Mary Hattie, nursing officer

Anne Craig, social work officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Since our last visit, staffing pressures throughout the service remains a key issue. We were told that staffing can be exceptionally difficult at times, mainly due to staff vacancies and a notable shortage of trained nurses (in one of the wards). There can be high numbers of agency and bank nurses on shift. Staff commented that recently there were improvements to this situation, in that the service was utilising fewer agency staff. On meeting with senior managers, they advised us of their recent recruitment drive, and the employment of newly trained nurses who were due to commence employment in September 2023. The service has also been recruiting to the local nursing bank, as they attempt to reduce the use and cost of agency nurses.

We also discussed the high levels of continuous interventions with individual being cared for in both wards; the service is having to use bank staff to manage this. Staff commented on the complexity of presentation of some individuals, who had to be supported by staff who may have had less experience, and how this could have an impact on the consistency of care. This matter was being closely monitored and managed.

Senior managers also informed us that they were in the process of collating and analysing data on the high levels of enhanced nursing observations. We look forward to hearing the outcome/action plan following on from the completion of this work.

Care, treatment, support, and participation

Throughout the visit, we saw kind and caring interactions between staff and individuals in the wards. We were keen to meet with as many individuals as possible on the day of the visit. Across both wards, those that we spoke with were very positive about the care and treatment they were receiving. They were positive about input from the medical and nursing staff and allied health professionals. The individuals we spoke to valued their relationships with the nursing teams, were aware of the role of the named nurse, and appreciative of their one-to-one meetings.

We heard comments such as “I feel safe in the ward, the nursing team really care about what they do”. We noted that the one-to-one meetings were well documented in individuals’ chronological notes; they felt that nursing staff were approachable and keen to “aid their recovery”.

We heard variable feedback from relatives that we spoke with. While we heard from a relative that the ward-based team were approachable and welcoming, and that there was good contact with the named nurse. For another relative, they stated that the service could improve on communication, and told us that they had concerns regarding their relative’s care and treatment; they commented on the lack of the involvement of advocacy services. We raised this matter at the end of day meeting. The staff were aware of the situation and were in the process of attempting to resolve issues that had been raised.

Care records

In both wards we found detailed 72-hour mental health assessments, along with risk assessments that were comprehensive and completed on admission to the service.

On our previous visit to Rutherford Ward, we made a recommendation regarding care planning and reviews. We were told about the auditing process for the care planning process. This audit is carried out by the senior nurse, who regular audits these to support improvement, quality, and governance.

On this visit we found that care plans were person-centred, and they addressed the full range of mental health and physical healthcare needs. We also saw evidence of the individual being involved, care plans having been discussed, and where appropriate, the care plans were signed. When we spoke with individuals, they were aware of the focus of the care plans and the nursing interventions that were documented in them.

We found the nursing care plan reviews to be meaningful, and they targeted nursing intervention and patient progress. However, there were three different recording systems in operation: for some individuals, reviews were on the back of the care plan, for others a typed review was held at the back of the care plans, and for others, the reviews were in the chronological notes on EMIS. We discussed this matter with the senior charge nurse (SCN) on the day, and we were told of plans to unify the system to ensure all staff are documenting their nursing care plan reviews in a consistent manner.

On our previous visit to McNair Ward, we made a recommendation regarding nursing care plans and the reviewing process. We found some care plans were person-centred and recovery focussed, however this was not consistent across all the plans we reviewed. We would expect that all care plans are person-centred and use a strength-based approach. Although comprehensive reviews of care took place, and they noted both changes in the individual's care, and on the impact of the nursing intervention, this information was not used to update the individual's care plan. This meant that some of the nursing care plans were not up-to-date and dynamic.

On our last visit we made a recommendation on the role of the one-to-one named nurse sessions, particularly in the documentation of these. We were pleased to see good evidence of one-to-one sessions recorded in the chronological notes. We heard that this intervention was appreciated and valued by those individuals that we spoke with on the day.

We noted in both wards that the CRAFT risk assessment framework was well embedded into practice, and that there were dynamic, individualised risk management plans that were reviewed regularly, updated, and highlighted the relevant areas of risk.

Nursing chronological notes were of a good standard, and there was evidence of liaison with families and carers.

Full physical healthcare assessments were noted to have taken place on admission and the follow up of these were evidenced in the notes where required.

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 in McNair Ward should ensure there is a regular audit process of individuals' notes in place, which includes ensuring that the care plan is person-centred, reflects and details interventions that support them towards their care goals. The summative nursing care plan review and evaluations should be integrated into the current care plan.

Multidisciplinary team (MDT)

The wards have a multidisciplinary team (MDT) on site consisting of psychiatrists, nursing staff, patient activity nurses, psychology, dietetics, occupational therapy, pharmacy, and social workers. Referrals can be made to all services, as and when required.

Individuals' care is reviewed weekly at the MDT meeting. Prior to the meeting, individuals are invited to record their views on a pre-meet format. This gives them the opportunity to participate in their care, discuss their progress, and also participate in the meeting. We found that this document was always completed prior to the meeting. However, for some of the records that we reviewed on the day, the actions and outcomes section of the meeting was not always recorded.

Recommendation 2:
Managers in Rutherford and McNair Wards should ensure that the notes from the MDT meeting contains information on outcomes, decisions taken, and actions required.

Use of mental health and incapacity legislation

On the day of our visit, in Rutherford Ward there were eleven individuals, and in McNair Ward, there were twelve individuals who were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Most of those that we met with during our visit had a good understanding of their detained status under the Mental Health Act.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to individuals, 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 available and up-to-date. In McNair ward, there was an omission on one T3 certificate, and this matter was raised with both SCN and managers at the end of day of the visit.

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

For one individual who we initially understood to be there voluntarily, we requested further clarity of their legal status, and queried if the patient was being detained unlawfully. We met with the responsible medical officer and as a result of this, the individual was reassessed and made subject to the Mental Health Act, with the relevant safeguards put in place.

Recommendation 3:
Managers in McNair Ward should audit consent to treatment documentation to ensure that all treatment is lawfully authorised.

Rights and restrictions

Both wards continue to operate a locked door with a keypad, this is commensurate with the level of risk identified with the patient group.

On the day of our visit to Rutherford Ward there were four individuals who required to have enhanced input through continuous intervention. In McNair Ward, this was in place for three individuals. These interventions had a significant impact on daily staffing.

We were told that both wards have access to independent advocacy and legal representation. The wards had contact details for both advocacy and legal advisors, and we were informed that leaflets and information were provided on admission. In McNair Ward we did not see leaflets to promote advocacy and those that we spoke with on the day did not appear to understand the role of advocacy.

Advocacy is the process of supporting and enabling patients to express views and concerns, and this service helps to independently support individuals in the promotion of their rights and to explore choices and options that are available to them. Mental health care services and practitioners should ensure that leaflets and posters about advocacy are available, and practitioners have a role in explaining what advocacy is and how to access the service.

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 an individual 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 wards and all respective 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 were reviewing individuals' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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.

On the day of our visit we did not see any advance statements on file, for those individuals that we reviewed. We encouraged staff to discuss the making of an advance statement as individuals' progress towards discharge and their mental health has improved.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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.

Recommendation 4:
Managers should ensure that individuals have access to advocacy services at all times whilst subject to any provision of mental health legislation.

Activity and Occupation

Both wards benefited from having their own dedicated patient activity co-ordinator nurse (PAC). The majority of those that we met with commented positively about the activities in the ward. Many spoke of the walking group, art and crafts, games and movie nights. For one individual we met with they felt "activities were not varied", and appeared to be delivered on an "ad hoc" basis.

In Rutherford Ward we heard about the new gym; they have been donated fitness machines and the service have accessed other gym equipment. This initiative was run jointly with the physiotherapy department, and there was a patient pathway in place prior to accessing the gym, ensuring individuals were assessed before commencing any programmes of exercise and fitness. We look forward to hearing more about this physical health initiative from individuals on our next visit to the service.

In McNair Ward, individuals stated that activities were varied. There was also evidence of individual timetable/plans, and the clinical team recorded in the chronological notes if the individual did not want to attend activities that were available.

Both services commented on the value of the voluntary services co-ordinator and the activities that they arrange on the wards. The "therapet" and the "musical events" activities were particularly appreciated.

The physical environment

On our last visit to Rutherford Ward, we made a recommendation regarding patient safety and security, and the need for appropriate fencing around the garden area. We were pleased to see that the fence had been erected and that the garden area was now enclosed.

The physical environments of both wards were maintained to a high standard, with the entrance corridor providing warm and welcoming introductions to both wards.

The layout of the wards consists of 20 single rooms with en-suite facilities. In each ward, one of the bedrooms is slightly larger; this can be used to accommodate patients with a physical disability, and there is an assisted bathroom. There are several seated areas that can be used and also a therapeutic activity room in each ward. There are large, separate dining areas.

The wards were bright, spacious and there are high windows that ensure natural light in the ward. The wards were clean, well decorated and maintained. There was access to an enclosed garden in each of the wards.

In McNair Ward we saw the new magnetic en-suite toilet doors. We found that the doors were unacceptable from both a privacy and dignity perspective. When the door is in place there are large gaps above and below the door, which could make the patients feel both exposed and vulnerable when using their en-suite area. We were also concerned about patient safety. We also heard from staff that the doors repeatedly fall off the hinges, and that the hinges are supported by a magnet. There is a very real risk of injury to patients. We were told that staff had expressed their concerns regarding this matter before the doors were installed. We raised this issue at the end of day meeting and have been advised that staff are involved in reviewing the design and identifying safe alternatives. We look forward to seeing those changes implemented on our next visit.

Any other comments

We heard from the senior manager about the plans for the psychology department to provide training and education in relation to current patient needs. Initial training will focus on metallisation-based treatment an integrative form of psychotherapy, bringing together aspects of psychodynamic, cognitive-behavioural, systemic, and ecological approaches to care.

The senior charges nurse also commented on the value of supervision/reflective practice that is available from the ward-based psychologist.

Summary of recommendations

Recommendation 1:
Managers in McNair Ward should ensure there is a regular audit process of individuals' notes in place, which includes ensuring that the care plan is person-centred, reflects and details interventions that support them towards their care goals. The summative nursing care plan review and evaluations should be integrated into the current care plan.

Recommendation 2:
Managers in Rutherford and McNair Wards should ensure that the notes from the MDT meeting contains information on outcomes, decisions taken, and actions required.

Recommendation 3:
Managers in McNair Ward should audit consent to treatment documentation to ensure that all treatment is lawfully authorised.

Recommendation 4:
Managers should ensure that individuals have access to advocacy services at all times whilst subject to any provision of mental health legislation.

Service response to recommendations

The Commission requires a response to these recommendations within three months of publication 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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