Mental Welfare Commission for Scotland

Report on announced visit to:
McNair ward, Gartnavel Hospital, 1053 Great Western Road, Glasgow, G12 0YN

Date of visit: 12 September 2024

Where we visited

McNair ward is a 20-bedded unit in Gartnavel Hospital that provides an acute mental health admission for individuals.

On the day of our visit, there were 20 people on the ward and no vacant beds.

We last visited this service in August 2023 on an announced visit and made recommendations in relation to person-centred care planning, recording of multidisciplinary team (MDT) meetings, authorisation of treatment and access to advocacy services. The response we received from the service was that auditing of care plans, MDT meetings and consent to treatment documentation had been put in place. We were also informed that information and contact details for advocacy services was available for all individuals.

On the day of this visit, we wanted to follow up on the previous recommendations and look at other issues that could have an impact on care and treatment, including the participation of individuals, families and/or carers.

Who we met with

We met with, and reviewed the care of seven people and we reviewed the care notes of one person. We did not meet with any relatives and/or carers.

We spoke with the service manager (SM), the senior charge nurse (SCN) and the lead nurse.

Commission visitors

Gemma Maguire, social work officer

Mary Leroy, nursing officer

What people told us and what we found

We heard from several people whom we met with that staff were 'supportive' and make them feel 'safe'. We also heard from some individuals that in previous admissions to the service they felt 'judged' by staff but now feel staff are 'nice' and 'understanding'.

We heard from the SCN that nursing staff are provided with complex trauma training and the SM discussed how the service is developing guidance for supporting individuals with emotionally unstable personality disorder. We look forward to hearing continued progress in this area of practice.

We heard from the SCN and the SM how the use of bank staff has reduced the need for agency staff, helping to maintain consistent staffing and manage risk during times of increased continuous intervention and/or staff shortages. Some individuals we met with told us that bank staff appear less 'experienced' compared to permanent staff, although they understood that bank staff can help ease pressure on the service. We heard from one individual how a bank staff member 'fell asleep' during a period of continuous intervention. Another person we met with told us that some bank staff are less 'patient' compared to permanent staff members. Where individuals had concerns regarding bank staff, they had shared these with nursing staff. We discussed these issues with the SCN and the SM on the day of our visit.

The SM and SCN confirmed that when concerns were raised, they were investigated and escalated appropriately in NHS Greater Glasgow and Clyde (NHS GGC) as per the established procedure. The SM informed us they were unaware what level of supervision and training bank staff receive as this is managed out with McNair Ward. The Commission are of the view that appropriate levels of supervision and training for bank staff should be clarified and will continue to follow this up with the service.

Some individuals we met with told us of the service pressures to free up beds that has previously led to them to be discharge from hospital too soon, or with little support. Where these concerns were raised, individuals were aware of their right to progress complaints. During this visit we found care plans, including those progressing towards discharge, to be person-centred with involvement from social work, occupational therapy (OT) and community mental health teams. The views of individuals and their families and/or carers were also clearly recorded in care records. The Commission will continue to follow up on individual issues regarding discharge planning.

All individuals we met with told us there was a good choice of activities available on McNair Ward. We also heard that people valued the input from OT, therapeutic activity nurse (TAN) and psychology services.

We were pleased to find that McNair Ward had addressed all of the recommendations made from our previous visit. We found evidence of improvements in person-centred care planning, the recording of MDT meetings, as well as appropriate authorisation for medical treatment. All individuals we met with were accessing or knew how to access advocacy services, with information available throughout the ward.

Care, treatment, support, and participation

Care records

During this visit we found significant improvement with care plans being person-centred, reviewed regularly and linked to MDT meetings. We found recovery focussed care plan evaluations, with individualised goals. Individuals were asked to sign care plans. Their views, and that of family and/or carers, were clearly documented. Several individuals we met with had a detailed understanding of their care goals and reported regular one-to-one time with nursing staff and their psychiatrist. Where individuals disagreed with their care and treatment, their views were recorded.

All care plans were accessible with the service transitioning from care plans being stored in paper files to the electronic recording system, EMIS. Risk assessments were reviewed timeously and updated accordingly.

Multidisciplinary team (MDT)

McNair Ward has a weekly MDT meeting that consisted of nursing staff, psychiatrist, OT, dietician, junior doctors, pharmacy, TAN, social work and psychology. Following our last visit where we had made a recommendation in relation to the recording of MDT meetings, we were pleased to find that MDT records related to person-centred care plans with a clear record of actions and decisions made at each meeting.

We are also pleased to hear individuals felt involved in meetings, with their views, and that of family and/or carers, being recorded.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All individuals we met with, including those who were informal patients and were aware of their rights and how to access legal advice if required.

All documentation relating to the Mental Health Act was clear and accessible.

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. 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.

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. Where a patient had nominated a named person, we found this was clearly documented in records with the named person appropriately consulted and views recorded.

All the individuals we met with and/or reviewed during the visit had capacity to make decisions, including consenting to medical treatment and were not subject to the Adults with Incapacity (Scotland) Act 2000.

Rights and restrictions

At the time of our last visit, we made recommendations in relation to individuals having appropriate access to advocacy services. On this visit all individuals we met with were aware how to access or were already accessing advocacy services. Information on local advocacy services was available throughout the ward. We also found evidence of advocacy being offered to individuals in care records.

For the individuals we reviewed who were subject to continuous interventions, we found person-centred and individualised interventions being carried out, with input from OT and psychology.

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 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. Where specified person restrictions were in place, we found a reasoned opinion in the care record with information about rights in relation to review being provided verbally and in writing to the individuals involved.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 any statements however were informed advance statements are discussed during one-to-one nursing sessions, reviewed at MDT meetings and were supported by advocacy services.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

McNair Ward benefits from its own TAN as well as having good access to OT and psychology services. Those we met with spoke positively about therapeutic activities, such as art and cooking and how these services were supporting recovery and developing skills.

We found care records provided a good evaluation of individuals' engagement with activity of the various choices on offer including access to a gym, tai chi classes, arts and crafts as well as functional OT assessments that were carried out to prepare individuals for discharge.

The service has support from a volunteer co-ordinator with therapy pets and musicians visiting the ward. The SCN informed us they have established links with 'Restart' via the health and social care partnership which provides individuals with recovery-based support through training and vocational opportunities.

The physical environment

McNair Ward continues to be maintained to a high standard with the layout consisting of 20 single ensuite rooms. The interior of the ward is bright and spacious, with appropriate access to space for therapeutic activities, receiving visitors, TV/lounge area and dining area.

The outdoor area provides a large welcoming space for individuals, with a variety of seating; it is well decorated with plants.

During our last visit we commented on use of magnetic bathroom doors in terms of patient safety, dignity and privacy. No one we met with raised concerns about the doors during this visit. We were advised by the SM that NHS GGC are continuing to use magnetic doors following environmental risk assessment and work is being carried out across inpatient services to ensure patient safety is maximised.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Service response to recommendations

There were no recommendations made from this visit.

We would 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, and ask the service to provide feedback regarding this.

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 an individual's care, treatment, and support are 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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