Mental Welfare Commission for Scotland

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

Date of visit: 26 April 2016

Where we visited

Clyde is an 18 bedded medium stay rehabilitation ward, one of two wards which provide the rehabilitation service for adults in Gartnavel Royal Hospital. It is a mixed sex ward. We last visited this ward on 5 March 2015 and made recommendations in relation to care planning, activity plans, discharge, and the physical environment.

On the day of this visit we wanted to follow up on the previous recommendations and concerns about the rehabilitation focus of the ward raised by a relative.

Who we met with

We met with seven patients.

We spoke with two of the charge nurses, staff nurses, the consultant psychiatrist, the occupational therapist and the clinical psychologist.

Commission visitors

Alison Goodwin, social work officer

Dr. Juliet Brock, medical officer

What people told us and what we found

Care, treatment, support and participation

We were told the past year has been a difficult time for staff on this ward due to staff sickness leading to shortages in trained staff and the use of bank staff, staff being required to cover other wards, interim senior ward staff and lack of a junior doctor to support the consultant who came into post. In the past week the ward had gained more nursing staff from the closure of Tate ward and a new ward manager was about to come into post. In addition the ward has a group of patients with very complex needs, including some with more continuing care needs and a number with quite challenging behaviour and additional issues with alcohol and drug use.

These issues had contributed to difficulties in establishing a focussed rehabilitation programme on the ward. Some rehabilitation work was being done within the limits that staffing has permitted. There was work by nursing staff with patients on personal care skills, on doing their own laundry and maintaining their bed spaces. The occupational therapist (OT), OT assistant with nursing staff were working with some patients on menu planning and cooking skills and use of community resources. These however are labour intensive activities requiring adequate staffing to support patients, particularly in accessing community resources.

Care plans were variable. Some were detailed and individualised, some were out of date. Many were formulaic and did not specify the interventions required or relate them to the individual e.g. ‘use distraction and diversion before considering PRN (as

required) medication' without specifying what those strategies were for that individual. Some had little in the way of rehabilitation goals and how these were to be achieved. Clear personalised care plans are important, more so when there are frequent changes in staff and they are not familiar with the patients.

We were pleased to see good nursing assessments completed monthly or two monthly which gave detailed updates on the patients physical and mental health, some of the rehabilitation work and plans towards discharge. It was also good to hear that a number of patients had been discharged in the last six months and that two were ready for discharge. Two other patients were 'delayed discharges' due to lack of appropriate accommodation or funding and are recorded on Edison. The Mental Welfare Commission (the Commission) will follow up these with the local authority. It may be useful for the ward to involve advocacy for these individuals.

There were up to date OT assessments in all the files we looked at. These had clear goals and the steps towards these goals but these did not translate into the nursing care plans in any consistent way. OT interventions were recorded and evaluated in the chronological record of care.

There was clinical psychology and pharmacy input to the ward.

There were regular multidisciplinary team (MDT) meetings with decisions and the required actions clearly recorded. We were told that most patients attended the MDT meeting. We saw very little recording of one to one time between the patient and their named nurse in the chronological notes to gather the patient's views and discuss and evaluate with them the rehabilitation focus of their stay on the ward.

There was partially completed annual physical health check documentation in patients' files. Some parts had been completed by nursing staff and some by the GP who comes in weekly to the ward. Most were incomplete. There were a number of patients who were eligible for the national bowel, breast and cervical screening programmes. Of the files we examined none had a record of the patient's health screening requirements on the annual health check form nor recorded whether screening had been carried out or attempted. One file had the bowel screening sample pack in his file that had been sent a month prior to our visit but it was not recorded in the notes as to how this was to be actioned.

In relation to medication a number of the high dose antipsychotic monitoring forms kept with the medication prescription sheets were very out of date with no recent recordings on them. These need to be urgently reviewed in line with the patient's current medication to update them or remove them, if they are no longer required. This was brought to the attention of the nurse in charge on the day and followed up by Dr Brock with the consultant psychiatrist.

Recommendation 1

The service manager should ensure there is a clear recovery based care plan for each patient with specific rehabilitation goals and detailed interventions to meet these.

Recommendation 2

The service manager should look at ways of encouraging patients' participation in their care and treatment plans and rehabilitation goals, including one to one time with their named nurse.

Recommendation 3

The service manager should ensure a review of the provision of nursing staff, psychiatry and OT to ensure they meet the rehabilitation needs of the patient group.

Recommendation 4

The service manager should ensure that every patient has an up to date annual health check completed, including screening where appropriate in line with the national programmes.

Recommendation 5

The service manager should ensure that the process for high dose antipsychotic monitoring is reviewed urgently.

Use of mental health and incapacity legislation

There were Adults with Incapacity (Scotland) Act 2000 (the Adults with Incapacity Act) spending plans in patients' files.

Some Mental Health (Care & Treatment) (Scotland) Act 2003 (the Mental Health Act) certificate authorising treatment (T3), did not authorise the treatment being given. Some detained patients were receiving treatment and there was no consent to treatment documentation with the medication prescribing sheets. This was brought to the attention of the nurse in charge on the day.

Recommendation 6

The service manager should initiate a review of all consent to treatment authorisation to ensure it meets the requirements of the MHA.

Activity and occupation

The OT and OT assistant had a programme of therapeutic activities for the ward. This includes breakfast groups and lunch groups, a soup group using vegetables grown in the Applefields garden (which a couple of patients help in), woodwork,

music groups and Therapet. Nursing staff provide support with personal care and housekeeping tasks, organise social events such as film nights and try to ensure people get use of their accompanied time off the ward. One of the nursing assistants supports people to do gardening in the ward garden. However, until the week of our visit, when extra staff became available, it has been difficult for nursing staff to really focus on promoting rehabilitation activity both on and off the ward. A number of staff felt the provision of a Patient Activity Coordinator (PAC) nurse, as on the acute wards, would be a very valuable asset to the rehab setting.

Some patients had support provided by outside agencies such as The Richmond Fellowship. There were not always clear records of what these staff were doing with the patient and how this contributed to their overall rehabilitation plan.

There were a number of out of date weekly activity plans in patients' files. We did not see current individual weekly activity plans in any of the notes we looked at. It was therefore hard to see the structure of the person's week and the overall therapeutic, social and recreational activities they were participating in without going through the chronological notes. This must also be an issue when OT, nursing staff, agency support staff, family and the patient are all contributing to the plan of activity.

Recommendation 7

The service manager should undertake a review of the programme of activities to promote rehabilitation to ensure it is adequate and effective.

Recommendation 8

The service manager should review the use of individual activity planners. It should include all the therapeutic, educational, social and recreational activities that are contributing to the patient rehabilitation programme so there is clarity for the patient and for staff.

The physical environment

The ward was clean and there is a large dining and sitting room as well as an activity room. However the physical environment did not support the function of a rehabilitation ward. Only six of the 18 patients on the ward had a single room, the other patients were in three dormitory areas. The activities of daily living (ADL) kitchen is very basic and would benefit from upgrading to a more appealing space where patients might also be able to eat what they have prepared. When we visited a year ago we were told there were plans for refurbishing the ward but this had not yet happened. We understand that the ward will be decanted shortly to the vacated Tate ward to enable Clyde to be upgraded.

The garden is a valuable asset to the ward, particularly for patients who only have escorted time off the ward. One of the staff and a few of the patients were interested in the garden and planed to do some planting as the weather improves.

Recommendation 9

The service manager should ensure the refurbishment of the ward is completed in a timely manner, supports the function of the ward and that patients and relatives are aware of the plans.

Any other comments

There was a problem with two overflowing wall-mounted cigarette ash cans and hundreds of cigarette butts in a trench by the back door to the garden. We were aware that there is an ongoing culture within the ward that poses a real challenge for nursing staff trying to impose restrictions. Whilst patients were aware of the hospital's smoking policy and had been encouraged by staff to participate in smoking cessation, some continue to smoke in public areas. This has implications for other patients and staff who do not smoke. There needs to be further discussion with hospital managers and across disciplines as to how to support the enforcement of the hospital policy in practice.

Recommendation 10

The service manager should ensure the garden is cleaned of cigarette ends.

Recommendation 11

The service manager should review the effectiveness of the implementation of the hospital's no smoking policy and discuss how staff can be supported in this.

Summary of recommendations

1. The service manager should ensure there is a clear recovery based care plan for each patient with specific rehabilitation goals and detailed interventions to meet these.

2. The service manager should look at ways of encouraging patients' participation in their care and treatment plans and rehabilitation goals, including one to one time with their named nurse.

3. The service manager should ensure a review of the provision of nursing staff, psychiatry and OT to ensure they meet the rehabilitation needs of the patient group.

4. The service manager should ensure that every patient has an up to date annual health check completed, including screening where appropriate in line with the national programmes.

5. The service manager should ensure that the process for high dose antipsychotic monitoring is reviewed urgently.

6. The service manager should initiate a review of all consent to treatment authorisation to ensure it meets the requirements of the MHA.

7. The service manager should undertake a review of the programme of activities to promote rehabilitation to ensure it is adequate and effective.

8. The service manager should review the use of individual activity planners. It should include all the therapeutic, educational, social and recreational activities that are contributing to the patient rehabilitation programme so there is clarity for the patient and for staff.

9. The service manager should ensure the refurbishment of the ward is completed in a timely manner, supports the function of the ward and that patients and relatives are aware of the plans.

10. The service manager should ensure the garden is cleaned of cigarette ends.

11. The service manager should review the effectiveness of the implementation of the hospital's no smoking policy and discuss how staff can be supported in this.

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.

Alison Thomson

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 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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