Mental Welfare Commission for Scotland

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

Date of visit: 14 September 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

McNair ward is a 20-bedded unit with single rooms that have en-suite facilities. The ward is for acute adult mental health assessment and provides care and treatment for male and female patients. On the day of our visit there was one vacant bed.

We last visited this service on 23 July 2019 and made recommendations in regard to care planning, the auditing of care plans, recording of meetings and one-to-one sessions, the inclusion of carers and relatives and maintenance of the garden area.

On the day of this visit we wanted to follow up on the previous recommendations and to hear how patients and staff have managed throughout the pandemic.

Who we met with

We met with, and reviewed the care records of, seven patients, five of whom we met in person and two of whom we reviewed the care notes of. No relatives or carers requested to meet with us.

We spoke with the senior charge nurse (SCN), the charge nurse and several other nursing and care staff. We were unable to meet with advocacy, although information on how patients could contact advocacy was clearly displayed on the ward notice board. We also met with the Hospital Manager.

Commission visitors

Anne Craig, social work officer

Margo Fyfe, senior manager

What people told us and what we found

Care, treatment, support and participation

Without exception, all the patients we spoke with praised the staff highly and one patient commented that his recovery was as a result of the staff team. Another said he felt the ward was his "safety net" and felt cared for and listened to. He referred to the care as "first class" and the nursing team were "fantastic". Another patient commented he felt "safe and secure" and the staff were "really good".

We were told that staffing was exceptionally difficult at times, mainly due to vacancies and annual leave, and that there was a shortage of staff on every shift. On the day of our visit, there was one patient on enhanced observations and this can also impacts on staffing levels. Short staffing has an impact on the ability to support patients with time off ward if they require to be accompanied.

Throughout the visit we saw kind and caring interactions between staff and patients. Staff who we spoke with knew the patient group well. We heard that there had only been one ward closure in the last year as a result of Covid-19 infection and that staff have worked hard, supported by infection control guidance, to contain the outbreaks successfully.

We heard about the work that had gone into supporting carers/families during the restrictions. There had been additional iPads made available to the unit, but many patients now have their own smartphones and don't require the use of the ward iPads as often.

It was clear from our interactions with the staff team that there was evidence of robust leadership and management on McNair Ward. In discussing this with the managers it was acknowledged that whilst leadership is not defined by one person's input, it is achieved through the support and direction from the nurse in charge.

Care plans

On review of the care plans, we saw a number of person-centred care plans but limited evidence of participation from patients or one-to-one time with staff. We saw that physical health care needs were being addressed and followed up appropriately through referrals to other services where required.

We did not find any evidence of one-to-one discussion between the nurses and the patients, although this was clearly happening due to the in-depth knowledge staff provided about the patients.

Care plans were reviewed, they were detailed and meaningful although each individual care plan was not reviewed separately; some care plans had seemed to have been created on a template with the patient's name inserted. We discussed this with the charge nurse during our visit who agreed to review the care plans, to ensure that they were not on a generic template.

We were told that the staff are aware that care plans and reviews are essential to the progress and recovery of patients and are optimising their ability to provide one-to-one support to their patients, whilst reflecting this in the paperwork. We suggested using the Commission

guidance on our website to help in the process and look forward to seeing an improvement in this area when we next visit.

There were care plan audits in place with recommendations at the end of each care plan review.

Recommendation 1:
Managers should regularly audit care plans to ensure they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 2:
Managers should ensure all one-to-one sessions between a patient and nurse are clearly documented in a patient's file.

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

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) of nursing staff, psychiatrists, occupational therapy staff, speech and language therapy staff and psychology staff who are either based in the unit or accessible to it. Referrals can be made to all other services as and when required

There are three consultant psychiatrists and junior doctors for the ward. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and update their views. This also includes the patient and their families should they wish to attend. McNair Ward uses a 'relative's contact sheet' and relatives are able to attend the MDT as long as the patient consents. It was clear to see from these notes that when the patient is moving towards discharge, community services also attend the meetings.

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. Continuing to hold these meetings in this way is being considered; however, the MDT is responsive to meeting in-person with additional input from online attendees. This ensures a comprehensive approach to in-patient provision from all services having input to patient care. This is in line with person-centred care provision and is particularly important as discharge is being considered. We were assured that family members wishing to attend, but who are not keen on using the online facility, will continue to be given the opportunity to attend in person.

Care records

In each of the patients' paper files we reviewed we saw a "welcome to McNair Ward" record. This was detailed and gave the patient information about the ward. We asked if the patient had a copy of this and were told that some patients did and some patients had declined to have it but it is available for them at any time.

We saw evidence of risk assessments being completed which were informative, person-centred and up-to-date. Information on patients care and treatment is held in two ways; there is a paper file and the electronic record system EMIS. The paper files and the electronic information are informative and comprehensive, and there is a clear link between the electronic information and paper records. Across NHS Greater Glasgow and Clyde area there is a plan for all records to be migrated to EMIS. This is progressing and we look forward to seeing paper-based documentation on EMIS for our next visit.

Use of mental health and incapacity legislation

On the day of our visit, nine of the 19 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Almost all of the patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act.

All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 200 (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date; electronic recording also provided information on the patient's status.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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 T2s and T3s had been completed by the responsible medical officer (RMO) to record consent/non-consent; they were available and up-to-date.

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 evidence of this in the patient's paper and electronic file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (AWI) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the AWI principles. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Where patients required a s47 certificate this was in place.

For patients who had covert medication in place, all appropriate documentation was in order. The Commission has produced good practice guidance on the use of covert medication at: https://www.mwcscot.org.uk/node/492

Rights and restrictions

McNair Ward continues to operate a locked door policy, commensurate with the level of risk identified in the patient group; entry to the ward is via a buzzer or keypad. Information on this is provided to families and other visitors although this was not visible on the day of our visit. We asked about this and were assured that there was a policy in place and would be re-instated as a matter of urgency. Restrictions due to Covid-19 are reducing and we found that

visiting had returned to near pre-pandemic arrangements. The only restriction to this is the availability of the two interview rooms where visiting takes place.

We were advised that there was one patient whose discharge from the ward had been delayed and one patient who was a specified person. Where specified person restrictions were in place under the Mental Health Act, we found the reasoned opinion in place. We spoke to another patient who had previously been a specified person, but he did not understand why. We spoke with the SCN and asked what information is provided when made a patient is made a specified person.

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.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advanced statements. The term 'advance statement' refers to written statements made under sections 274 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 saw no evidence of advance statement recording. We discussed this on our visit and suggested that whilst this is an acute admissions ward it may not be appropriate to discuss advance statements during the early stage of admission but should be key to discussion at the discharge planning stage.

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

Activity and occupation

We are aware that during the pandemic, restrictions that were put in place meant that various activities out with the unit had to be put on hold, and that some patient groups struggled with this change to their routine. We heard from one patient who felt that there was a lack of activity for the patients and felt that activities needed to be more structured, and that someone should "sweep up all the patients and encourage and motivate them to get involved in doing something". However we spoke with another patient who said activities were detailed on the activities board if you wanted to join in. The ward does have a patient activity nurse in post.

Now that restrictions are beginning to lift, patients are once again able to resume community activities. We heard that staff have gone the extra mile to facilitate activity and ensure patients' activity needs are met.

The physical environment

The layout of the ward consists of 20 single rooms with en-suite facilities. Two rooms are slightly larger and can accommodate patients who have any physical disabilities and there is

an assisted bathroom. There are several lounge areas that can be utilised by the patients as they wish, and some quiet areas, some that are larger, with TV and games. One room at the end of the corridor has been furnished with comfortable chairs and a lounger, with privacy screening from the garden area. There is a large separate dining area for the patients. The ward is bright, spacious and welcoming with high windows. Many of the windows had been decorated by the patients and reflected the seasons; this has added to the personalisation of the main ward area. The environment was immaculate and we were able to see where efforts have been made to soften all the public rooms.

Patients have access to a large garden area which is shared by other wards. It is well kept, and patients can, and do, help with the maintenance of the garden area.

Summary of recommendations

Recommendation 1:
Managers should regularly audit care plans to ensure they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

Recommendation 2:
Managers should ensure all one-to-one sessions between a patient and nurse are clearly documented in a patient's file.

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.

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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