Mental Welfare Commission for Scotland

Report on announced visit to: Henderson Ward**,** Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0YN.

Date of visit: 15 August 2017

Where we visited

Henderson ward is a 20-bedded acute mixed-sex ward, with single room en-suite accommodation.

We last visited the service in June 2016 as part of the Mental Welfare Commission's national themed visit to Acute Adult services in Scotland. The previous visit to this service was in May 2014 as an unannounced focussed visit. At that time we made recommendations about: mental health legislation paperwork being up to date and provision of art work in corridor areas.

On this visit, we wanted to follow up on the previous recommendations and also look at care planning documentation and practice, to ensure it is recovery focussed, physical health and activities.

These themes are identified from our Adult Acute Themed visit report as areas that services may need to improve.

Who we met with

We met with and or reviewed the care and treatment of eight patients.

We spoke with the ward manager, senior charge nurse (SCN) and other nursing staff.

Commission visitors

Mary Leroy, Nursing Officer (visit coordinator)

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

All the interactions towards patients we observed were friendly and supportive. The patients we interviewed generally spoke favourably about their care and treatment and that staff were supportive and approachable.

Care plans were person centred and detailed in terms of physical and mental health. There was also evidence that the patient's strengths and abilities were reflected within the care plans. The care plans were well evaluated and reviewed.

Risk Assessment and safety plans were reviewed on a regular basis: this was either on a daily basis, or weekly by the key nurse and also through the Multidisciplinary team (MDT) meeting. We met with one of the ward-based nurses who is the ward liaison nurse for the Scottish Patient Safety Programme. She informed us that the service had recently focussed on the risk assessment and safety planning admission bundle. This model ensures that there is excellent detail on historical risk and current

triggers, including actions on how to reduce triggers. This process involves discussion with the patient and, when relevant, the family, and the implementation of a comprehensive risk assessment and safety plan for every patient to minimize incidents whilst also promoting recovery. We were pleased to see this comprehensive approach was reflected in the patients current risk assessment and safety plans.

There was evidence of patient involvement in the MDT meeting and in the compilation of care planning. Entries within the chronological notes were generally to a good standard. The notes evidenced a MDT approach to care, with contributions from medical staff, nursing staff and allied health professionals.

There is a daily MDT meeting, the ward has five consultants. The consultants have frequent contact with the ward and patients. The system that is in place for the MDT meeting, initially all members of the MDT meet, following this the consultant and relevant others will meet with the patients and carers. We were informed that most of the patients participated in the feedback interview following the MDT. The clinical discussions that occurs within the meeting are well documented and generates a clear action plan with treatment goals. The MDT meeting is attended by the crisis team, support workers and relevant community team members.

The SCN discussed the 'triangle of care standards'. This is applied to practice through ensuring that the family know and have contact with the patient's named nurse, within the chronological notes we saw evidence of frequent communication with families, documented discussion, telephone calls and meetings with Consultants. On the day of our meeting we were unable to meet with any carers. The SCN informed us that the patient activity coordinator nurse had organised a carers meeting in the past he comments "that the meetings were not well attended".

Psychology input is on a referral only basis, staff comment that most of the patients who access psychology are referred for rehabilitation assessments. All the nursing staff are trained in MBT, this approach underpins clinical understanding, the therapeutic relationship and therapeutic change. The psychology service provide the staff team with monthly supervision in this approach.

We heard there was regular input from pharmacy and referrals to allied health professionals e g: dietetics, physio.

There was good attention to physical healthcare needs; a full medical assessment on admission with regular physical health check monitoring and referral to specialist services if required. When we were reviewing the patient's care plans we saw evidence of two patients with a presenting chronic health condition that did not have an appropriate care plan to help support and manage their physical conditions. We raised this with the staff on the day or our visit.

There was evidence of some health promotion initiatives, such as smoking cessation support, dietary advice and support to exercise.

The advocacy service within the ward is available on a referral basis, There was an information leaflet on display and available on the ward. We were told there is good advocacy input to the ward.

We asked staff about the promotion of advance statements within the service. We were advised that the nursing staff have these discussions with the patients as the patients begin to recover from their acute episode of illness.

Use of mental health and incapacity legislation

On the day of our visit, nine of the patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003, the remaining patients were informal.

The copies of the certificates authorising detention under the Mental Health Act were in the patients notes. However, the whiteboard in the office with information on the patient's legal status and also information accessed in the chronological notes was incorrect, not accurately reflecting the patient's current legal status.

We examined drug prescriptions and treatment certificates (T2/3). All the consent to treatment certificates to authorise medication were in place. There were two certificates that were not in the prescription folder which were being reviewed on the day of our visit.

One of the patients interviewed appeared to lack capacity to consent to treatment for their physical care, we raised this with the staff on the day. We advised that the medical staff should review the patient with regards to his capacity to consent to his physical treatment under the Adults with Incapacity (Scotland) Act 2000. Staff must also ensure s47 certificates and treatment plans where required are completed and kept with medication charts.

Recommendation 1:

Managers should ensure a system is implemented and audited regarding the recording of patient's legal status. There is a need to ensure that information relating to the patient's legal status is documented, current and accurate within the patient's file and on the ward white board.

Rights and restrictions

On the day of our visit none of the patients were on enhanced observations**.** We were also informed that none of the patients were delayed discharge. Staff commented that there were good links with social work and there had been no recent issues progressing discharge for patients.

Activity and occupation

Patients we met with commented that they felt bored on the ward. Three patients also commented that the activities that were on the day we visited, did not usually occur.

Staff disagreed with this suggestion about the lack of activity, and evidence of a programme of activities support this. We saw some evidence in the chronological notes of activities, relaxation and access to gym activities.

The ward has a patient activity coordinator nurse. There were a range of activities on offer available within the ward. Activities were delivered in one to one sessions or group work. There is a small activity room on the ward with facilities for art and games.

The occupational therapist (OT) on the ward provides a range of services including functional assessments, individual sessions plus preparation for discharge. Within the patients files there were comprehensive OT assessments with detailed outcomes and were recovery focussed.

Recommendation 2:

Managers should ensure there is an adequate provision of activities in the evenings and at weekends

The physical environment

The ward was clean, bright and maintained to a high standard. There were pictures and artwork on the walls, providing more visual interest in communal areas. All small sitting areas were comfortable and well furnished. The ward also has a small sitting room for female patients only. The garden area is pleasant and well maintained and easily accessible for all.

Any other comments

On the day of our visit, the ward manager raised his concerns regarding the moving of patients who are deemed to be 'stable' to other wards within the hospital. The stable patient is defined as a patient who is moving towards the end of their hospital admission, but is not ready for discharge. The staff feel this is impacting on the patient's recovery and care. The staff we interviewed on the day of our visit felt the moving of stable patients is not person centred and is disruptive to patient care.

Summary of recommendations

1. Managers should ensure a system is implemented and audited regarding the recording of patient's legal status. There is a need to ensure that information relating to the patients legal status is documented and is current and accurate though out the patients file and on the ward white board.

2. Managers should ensure there is an adequate provision of activities in the evenings and at weekends

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
Executive Director (social work)

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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