Mental Welfare Commission for Scotland

Report an announced visit to: Rutherford Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XN

Date of visit: 5 September 2017

Where we visited

Rutherford ward is a 20-bedded acute mixed-sex ward, with single room en-suite accommodation. We last visited this 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 the time we made recommendations about: mental health legislation paperwork being up to date, provision of art work in corridor areas.

On the day of 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 were identified from our Adult Acute themed visit report as areas that services may need to improve.

Who we met with

We met with and reviewed the care and treatment of five patients.

We spoke with the charge nurse and other nursing staff.

Commission visitors

Mary Leroy Nursing Officer (visit coordinator)

Mary Hattie Nursing Officer

What people told us and what we found

Care, treatment, support and participation

All the interactions we observed towards patients on the day were friendly and supportive. We heard positive comments about staff from the patients we met.

Care plans were person centred and detailed in terms of physical and mental health. There was some evidence that the patient's strengths and abilities were reflected within the care plans, the care plans were well evaluated and reviewed. We saw an excellent example of care plan where specialist services had been working jointly with the nursing staff to ensure that the individual's needs were being met. This collaborative approach to care, evidenced a reduction in the patient's anxiety and an increase in engagement in therapeutic activities. This care and treatment was also well documented with in the patient's chronological notes.

Risk Assessments and safety plans were reviewed on a regular basis: this was on a daily basis, or weekly by the key nurse and also through the Multidisciplinary team (MDT) meeting.

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

The charge nurse 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 patients file 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.

We were informed that there was no psychology input into the ward. Patients who needed input from the psychology service received this on an outpatient basis. The service are currently training the staff in mentalised based therapy (MBT), the first group of staff have attended and are near completion of the training, there are plans to train all staff in this approach. Three of the nursing staff have also completed spirit training.

The ward receive input from Pharmacy: the pharmacist attends the ward on a weekly basis to review medical prescribing. Pharmacy staff review the medication prescribed for each individual on the day following admission.

We saw good attention to physical healthcare needs, a full medical/physical assessment on admission with regular physical health checks monitoring. The staff informed us that the Patient Activity Nurse facilitates a monthly clinic where all patients receive regular physical health monitoring.

Peer support workers (people with lived experience of mental illness and recovery). are increasingly recognised for their work in supporting patients. The ward has input from the Peer support worker on four mornings a week. We heard positive feedback from patients and staff on the contributions the peer support worker makes towards recovery. The Peers support workers within the ward lead on assisting patients to complete their Wellness and Recovery Action Plans (WRAP).

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. There was also evidence of advocacy involvement with patients within the file.

We asked about the promotion of advance statements within the service. We were informed by the nurses that they would raise awareness of the advance statement with the patient, as they were beginning to recover from their episode of ill health. We saw advance statement booklets on display in the patient areas on the day of our visit.

Use of mental health and incapacity legislation

The copies of the certificates authorising detention under the Mental Health (Care and treatment) (Scotland) Act 2003 were not in some of the patients' notes**.**

We observed inconsistencies and errors in recording of patient's current legal status throughout several notes. We interviewed a patient who believed they were subject to the Mental Health (Care and treatment) (Scotland) Act 2003, but were in hospital on an informal basis. Within the notes we also observed that a visiting doctor was unable to ascertain a patient's legal status due to the confusing recording throughout the patients file.

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.

We examined drug prescription sheet and consent to treatment (T2) certificates and certificate authorising treatment (T3) certificates. We were unable to locate two of the consent to treatment certificates, one we could not access the staff member could not find it, and the other one was in the patient's medical notes. The RMO must ensure that prescriptions of medications for detained person are properly authorised, with a T2 or a T3 form in place where this is required by law. The above issues were brought to the attention of the nurse in charge so they could be remedied as quickly as possible

Recommendation 2:

Manager should ensure that a system should be implemented and audited to ensure that the correct paperwork (e.g T2 and T3 form) is in place and accessible for patients subject to the Mental Health (Care and treatment) (Scotland) Act 2003.

Rights and restrictions

We evidenced in the notes that some patients that were not subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 were having their time out of the ward restricted with the comment "nil time out" documented on the patients file. We saw no evidence of any collaborative approach to gain the patients consent or agreement to this restriction. We discussed each situation with senior staff on the day and asked the question when we thought that a patient was having their liberty restricted or deprived. Information re: patients' rights can be found on our website at http://www.mwcscot.org.uk/rights-in-mind/

Recommendation 3:

Managers should ensure that medical and ward staff are fully aware of the required legal authority to restrict patients from leaving the ward.

Activity and occupation

Patients we met with commented that they felt bored on the ward and there was a lack of purposeful activity, one patient commented that "there used to be more activity but that doesn't happen now". We saw some evidence in the chronological notes of activities.

The ward has a patient activity coordinator nurse, there were a range of activities on offer available within the ward ranging from walking, gardening, craft and relaxation activities. The PAC nurse also runs some recovery focussed therapeutic groups; self-esteem building, assertiveness and positive thinking. There are two small activity rooms on the ward one for art and games, the other one is used for music and relaxation activities.

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 4:

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

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.

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 patient's legal status is documented, current and accurate within the patient's file.

2. Manager should ensure that a system should be implemented and audited to ensure that the correct paperwork (e.g.T2 and T3 form) is in place and accessible for patients subject to the Mental Health (Care and treatment) (Scotland) Act 2003.

3. Manager should ensure that medical and ward staff are fully aware of the required legal authority to restrict patients from leaving the ward.

4. 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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