

**Mental Welfare Commission for Scotland**

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

**Date of visit:** 6 September 2017

## **Where we visited**

McNair 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 (MWC) 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. We also looked at 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 six patients and met with one carer.

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

## **Commission visitors**

Mary Leroy, Nursing Officer (visit coordinator)

Mary Hattie, Nursing Officer

Ritchie Scott, Medical Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

There was a calm atmosphere in the ward. All the interactions towards patients we observed from staff were friendly and supportive. Staff were knowledgeable about the patients when we discussed their care. We heard positive comments about staff from some patients we met.

There was evidence of good medical assessments and assessment by the nursing staff. Care plans were person-centred and detailed in terms of physical and mental health. There was also evidence that the patients' strengths and abilities were reflected within the care plans. These plans promoted patient participation and were recovery focussed. The care plans were well evaluated and reviewed.

Risk assessment and safety plans gave a clear history of risk, identified triggers and coping strategies were within the supporting action plan. The risk assessment and safety plan 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 the ward liaison nurse for the Scottish Patient Safety Programme. We were informed that the service had recently focussed on the risk assessment and safety planning admission bundle. We were pleased to see this comprehensive approach was reflected in the patients' current risk assessment and safety plans. The service is now focussing on the communication of the transition.

There was evidence of patient, and when relevant family, involvement in the Multidisciplinary Team (MDT) meetings and in the compilation of care planning. The notes evidenced a MDT approach to care contributions from medical staff, nursing staff, allied health professionals and social workers. The ward manager informed us that the medical staff have frequent contact with the ward and patients. The clinical discussions that occur within the MDT meetings are well documented and generate a clear action plan with treatment goals. The MDT meetings are attended by the crisis team, support workers and relevant community team members. Entries within the chronological notes were generally to a good standard.

The ward manager 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 met with one carer.

We discussed psychology input into the ward, we were informed that there was no inpatient funding for this service. Most of the patients who accessed psychology did this through the community services. Some of the nursing staff were trained in mentalisation based treatment. This approach underpins clinical understanding, the therapeutic relationship and therapeutic change. The psychology service provided the nursing staff with monthly supervision in this approach.

The ward received input from pharmacy: the pharmacist attended the ward on a weekly basis to review medical prescribing. The ward staff commented that the pharmacist also monitored patient's health and progress to optimise their response to medication. They were also very helpful with the nursing team with giving advice on medication and with any health promotion activities relating to medication.

There was good attention to physical healthcare needs including a full medical assessment on admission with regular physical health check, monitoring and referral to specialist services if required. 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 was 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 discussed with the ward manager the promotion of advance statements for patients. The team attempt to promote this as the patient progresses towards recovery. We saw advance statement booklets on display in the patient areas on the day of our visit.

We were informed that there is a monthly patient meeting where the patients discuss and raise concerns regarding the ward.

### **Use of mental health and incapacity legislation**

On the day we visited, seven patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA). We were pleased to find all consent to treatment (T2) and forms authorising treatment (T3) under the MHA all in order.

Adults with Incapacity (Scotland) Act 2000 (AWI) s47 consent to treatment authorisations were in order, along with accompanying care plans where necessary.

We were informed that all MHA and AWI paperwork is regularly audited and monitored.

### **Rights and restrictions**

On the day of our visit no patients were on enhanced observations.

We saw evidence in the notes that some patients who were not subject to the MHA were having their time out of the ward restricted with the comment 'nil time out' documented on the patient's file. We saw no evidence of any collaborative approach to gain the patient's consent or agreement to this restriction. We discussed individual cases with the senior staff on the day. The MWC has created a rights pathway designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. The pathway and a good practice guide can be accessed online at <http://www.mwscot.org.uk/rights-in-mind/>

### **Recommendation 1:**

Managers need to ensure that medical staff and ward staff are fully aware of the required legal authority to restrict patients from leaving the ward and ensure that patients have their legal status explained including any deprivation of liberty.

### **Activity and occupation**

The ward had a patient activity coordinator (PAC) nurse. He is employed on a full time basis, and also worked over the weekend to provide weekend activity. There were a range of activities available within the ward ranging from walking, gardening, craft and

relaxation activities. The PAC nurse also ran some recovery focussed therapeutic groups. The service used a whiteboard to ensure patients were aware of what activities are available on a daily basis. We saw evidence within the notes of patients being engaged in a range of 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.

### **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 had a small sitting room for female patients only. The garden area was pleasant and well maintained and easily accessible for all.

### **Summary of recommendations**

1. Managers need to ensure that medical staff and ward staff are fully aware of the required legal authority to restrict patients from leaving the ward and ensure that patients have their legal status explained including any deprivation of liberty.

### **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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