

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Clyde Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

Date of visit: 7 March 2017

Where we visited

Clyde is an 18 bedded medium stay rehabilitation ward in Gartnavel Royal Hospital (GRH). The service aims to provide each patient with a graded rehabilitation programme, following a multidisciplinary assessment to determine their strengths and set recovery focussed goals to improve their life skills and their social and emotional wellbeing.

The service has been subject to significant review over the past few years, and there have been considerable changes in Clyde ward since our visit in April 2016. On the day of our visit there were nine patients in the ward. The patients in the unit have complex mental health difficulties and physical health issues. Some have been in hospital for many years, others have had multiple admissions when community placements have broken down.

We last visited this service on in April 2016. At that time there were considerable issues with staffing which impacted on patient care, including sick leave and maternity leave. In response, a senior charge nurse was moved from another area and staff were moved from the recently closed Tate ward. These issues contributed to difficulties in establishing a focussed rehabilitation programme on the ward. There was also a very diverse group of patients in the ward and one of the recent changes is to have much clearer criteria for admission to the service. Nine of these patients have now been discharged, mainly to care homes, and on the day of our visit there were nine patients in the ward. Two of these patients do not really meet the criteria for the ward and alternatives are being explored.

We visited on this occasion to ensure the service review and the action plan following our recommendations last year were improving patient care and to give patients an opportunity to raise any issues with us.

We also looked at:

- Care and treatment and service user participation
- Use of legislation
- Rights and restrictions
- Therapeutic activity
- Physical environment

Who we met with

We met with five patients. We looked at their records and those of one other patient. We spoke with the senior charge nurse, the charge nurse, one of the staff nurses and the consultant psychiatrist.

Commission visitors

Alison Goodwin Social Work Officer

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

We met with five patients, who were generally positive about the care and treatment provided by the nursing staff and the allied health professionals and had no concerns to raise.

The change in leadership and staffing in the ward has brought about a substantial shift in the culture of the ward. There is a very diverse group of patients in the ward. Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their motivation to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. However, we saw great efforts by the nursing staff, the occupational therapy (OT) staff and the psychiatrist to encourage patient involvement in both their treatment and activities. There appeared to be a much more purposeful focus on rehabilitation which was understood by the patients. We were particularly impressed with the motivational work being done by staff through various creative activities.

Risk assessments are in place and are reviewed regularly. There are excellent and detailed nursing assessments completed, using the five areas model. These are done on a monthly basis and clearly inform the evaluation and update of care plans.

The care plans are still variable. Some are person-centred, recovery focussed and detailed in terms of physical health, mental health and social needs. It was clear that staff knew the patients well and their care and treatment was appropriate to the patients' current needs. Other care plans or certain sections of them are formulaic and do not clearly specify the interventions required or relate them to the individual. Overall, the plans are much better than on our last visit and the senior charge nurse is aware this is a work in progress. There are multidisciplinary team (MDT) meetings with decisions and required actions clearly recorded.

There are good OT functional assessments and reviews for all the patients. There is a full time OT and a full time OT technician who cover the two rehabilitation wards. There is also involvement of clinical psychology and pharmacy as required.

Many of the patients have physical health issues which are addressed by the GP who attends the ward on a weekly basis or more if required. Last year we had concerns that annual health checks had not been completed for some patients, and there was no clear record whether screening had been carried out where patients were eligible

for national bowel, breast and cervical screening. We were pleased to see that all patients had had an annual health check in May 2016 and eligibility for screening and whether it had been carried out were documented as part of this. Where screening had been refused, we were told that this had been readdressed with patients. It would be useful, however, if this was also recorded on the form to evidence these efforts.

An audit system has been put in place to ensure high dose monitoring is carried out where required. Unfortunately, a number of the monitoring forms in the medication charts had not been updated, though we were told the actual monitoring, such as bloods, had been done.

We noted there is no life history information for patients in the files. We consider this is important in delivering person-centred care and there should be some way of gathering and recording this information with the patient.

We were pleased to note the systems that have been put in place to support patient care and treatment and some of the imaginative ways staff and patients have been involved in creating a more positive rehabilitation ethos in the ward.

Recommendation 1:

The service should ensure high dose monitoring records are up to date.

Recommendation 2:

The senior charge nurse should ensure there is life history information on each patient in their records.

Use of mental health and incapacity legislation

In some cases, the medication being given was not covered by the consent to treatment forms under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA). This was pointed out to the nursing staff on the day and will be rectified.

We only saw one treatment plan and no s47 certificates under the Adults with Incapacity (Scotland) Act 2000 (AWI). We saw a number of patients who appeared to have limited understanding of their physical health issues and the treatment they were receiving for these. It would be useful for the GP to review all the patients on the ward in relation to their capacity to consent to treatment under the AWI Act and ensure s47 certificates and treatment plans, where required, are completed and kept with the medication charts.

There are good personal spending plans for those patients whose funds are managed under Part 4 of the AWI Act. We saw efforts to encourage spending on appropriate items and think of ways patients could benefit from their money.

Recommendation 3:

The service should ensure all consent to treatment authorisation required under the Mental Health Act and the Adults with Incapacity Act accurately reflects what is being prescribed and is available with the medication charts, so staff are clear under what authority they are administering medication.

Rights and restrictions

We were told that there is involvement from advocacy services with one patient and that one patient has an advance statement*. We had some discussion with the nursing staff about encouraging patient participation through the use of advocacy services and advance statements.

*An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future.

Activity and occupation

There is good OT input to the ward with an OT and an OT technician covering the two rehabilitation wards in GRH. There are functional assessments completed for all patients. Most patients are involved in meal planning, shopping and preparation of two lunches and two evening meals per week in the activities of daily living (ADL) kitchen and nursing staff also do some cooking and baking with patients. A new cooker and freezer have been purchased for the ADL kitchen since our last visit and this has improved the facility. All patients do their laundry, keep their bed areas clean and tidy and attend to their personal hygiene with varying degrees of support from nursing staff. Unfortunately, the washing machine has been broken for the last month and a replacement has not yet arrived, so patients are currently unable to do their own laundry on the ward.

There is also a ward activity programme which is clearly displayed along with the name of the staff member leading the activity. Where no one wants to participate in the activity, an alternative is proposed and that is recorded in activity diary. There is a good range of activities including relaxation, newspaper groups, the Common Wheel music group, pampering and an evening art group run by two volunteers. The ward has purchased a pool/air hockey/ table tennis table, which is popular, as well as a games console, art materials, books and sensory equipment. There are also plans to start a bike group. We saw some excellent art work that many of the patients had participated in, including a large giraffe sculpture and a dragon/phoenix mural on the wall of the activity room.

Each person has a laminated individual monthly programme of activities which includes activities of daily living and therapeutic and social activities on and off the

ward. This all contributes to the improvement in the rehabilitation activity programme since last year.

The physical environment

The ward is clean and reasonably well maintained. There is a large sitting/dining/activity room. We noted that new furniture including seating and dividing units have improved this area, along with the improvements in the equipment in the ADL kitchen. The issue of the washing machine to enable patients to do their own laundry needs to be addressed urgently.

There are three four-bedded dormitories and six single rooms in the ward, and in this regard it is an unsuitable environment as a rehabilitation setting. Currently, due to the numbers in the ward, the dormitory areas only have one or two people in them but this is a temporary situation.

We were told on our last visit that the ward was to be decanted to Tate so that Clyde could be refurbished. Subsequently, we were told the work on Clyde was scheduled for 2017 and that there is a regular monthly review which looks at the wider capital programme. Ward staff, however, are unaware of a timeframe for any major refurbishment. The Commission would like to be informed of the proposed dates for refurbishment of these wards.

Recommendation 4:

The service should ensure the provision of a washing machine on the ward as soon as possible.

Summary of recommendations

1. The service should ensure high dose monitoring records are up to date.
2. The senior charge nurse should ensure there is life history information on each patient in their records.
3. The service should ensure all consent to treatment authorisation required under the MHA and the AWI Act accurately reflects what is being prescribed and is available with the medication charts, so staff are clear under what authority they are administering medication.
4. The service should ensure the provision of a washing machine on the ward as soon as possible.

The Commission would also like to be updated on the plans for the refurbishment of the rehabilitation wards in GRH.

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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