Mental Welfare Commission for Scotland

Report on unannounced visit to:
Rutherford Ward, Gartnavel Hospital, 1053 Great Western Road, Glasgow, G12 0YN

Date of visit: 21 January 2025

Where we visited

Rutherford Ward is a 20-bedded acute adult assessment unit (AAU). On the day of our visit, there were 19 people on the ward with one person on pass; there were no vacant beds.

We last visited this service in August 2023 on an announced visit and made recommendations in relation to recording of multidisciplinary team meetings (MDT) and ensuring individuals have access to advocacy. The response we received from the service was that preparation, including the use of checklists, is carried out prior to MDT meetings and agreed outcomes are clearly recorded. We were also advised that information regarding advocacy is displayed on the ward, with leaflets given to individuals and that staff record when advocacy information is discussed with individuals.

On the day of this visit, we wanted to follow up on the previous recommendations and look at any other issues impacting care and treatment.

Who we met with

We met with, and reviewed the care of five people, and we reviewed the care notes of one further person.

We spoke with the service manager (SM), senior charge nurses (SCN), the charge nurse and bank staff.

Commission visitors

Gemma Maguire, social work officer

Paul Macquire, nursing officer

What people told us and what we found

We heard from those individuals that we met with that staff were “great” and “nice”. Many of the individuals we met with were aware of their rights, had access to legal advice and were either involved with advocacy or knew how to access this service.

On the day of our visit, the SCN informed us that several individuals were “boarding out” in other wards and the demand for inpatient beds continues to place pressure on the service. We were also advised by the SM that there is a lack of bed capacity across various inpatient mental health services in NHS Greater Glasgow and Clyde, as well as nationally. We heard how managers continue to have daily bed management meetings to discuss risk and prioritise resources.

On the day of our visit, a member of nursing staff was unexpectedly absent and the SCN informed us that the patient activity co-ordinator (PAC) nurse, as well as bank staff were being used to meet the required number of clinical staff in order to manage risk and ensure patient safety. The SCN advised the availability of staff to support activities can be reduced when such situations arise. Despite these reported difficulties, we were pleased to find that individuals were being offered a range of ward-based activities such as Tai Chi, as well some people being supported out on escorted leave.

We also found the atmosphere on the ward to be calm and observed staff to be warm and caring towards individuals throughout our visit. We met with a bank member of staff who told us they have “chosen” to return to the ward having had many “positive” experiences working for the service previously.

The SCN advised us that the ward has good links with social work and community mental health teams in order to support individuals with their discharge from hospital. On the day of our visit, we were advised that those currently admitted to the service had been there for less than one year and no one was considered to have their discharge from hospital delayed.

Care, treatment, support, and participation

All care records, including care plans, MDT records and risk assessments, were accessible on the electronic recording system, EMIS. On the day of our visit, we were informed by SM and SCN that the service has introduced a new person-centred care plan template with all care plan information, including reviews, being updated on one document.

We found care plans to be person-centred, with review of an individual’s progress towards agreed goals. We were pleased to find some individuals had a separate ‘mental health review’ document, which clearly evidenced person-centred reviews. We discussed the positive use of this document with the SCN, who advised us that a newly qualified member of nursing staff was completing these for individuals they

were keyworker to. We advised the SCN that such good practice would be helpful for the service as a whole to consider and shared widely as part of practice development. We look forward to hearing how this develops.

When reviewing individual care records, we found that individuals had a risk assessment completed upon admission. However, when we reviewed the documentation for this, we found it was inconsistent in terms of updates; for some individuals this assessment had not been updated despite there being an increase in either the risk to themselves and/or others. We discussed with SCN on the day of our visit and were advised, in line with service policy, that risk assessment documents should be updated when there is a change in the level of risk. We advised SCN that audit processes should be implemented by the MDT to ensure consistency in the review of risk assessments.

Recommendation 1:
Managers responsible for Rutherford Ward should carry out auditing of risk assessment documentation to ensure consistency of reviews.

Multidisciplinary team (MDT)
MDT meetings continue to be held weekly and consist of consultant psychiatrist (CP), psychology, pharmacy, occupational therapy (OT), physiotherapy and the PAC nurse. We are pleased to find that since our last visit, the recording of MDT meetings has improved, with records evidencing who attended and agreed actions relating to individual care plans.

Use of mental health and incapacity legislation

On the day of the visit, 10 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All individuals detained under the Mental Health Act were aware of their rights. Several individuals had nominated a named person, and we found that others were receiving legal advice and accessing advocacy services.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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.

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 documentation to be accessible and the named person to have been appropriately consulted.

On the day of our visit there were no adults who were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). We reviewed the care records of one individual who was appropriately undergoing assessment of their capacity with specific decisions, following concerns identified by staff upon their admission to the ward. We were pleased to see that communication was taking place with family, including checking if a power of attorney was in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. For the individual who was undergoing assessment of their decision-making capacity, this included a review of their decisions in relation to medical treatment. We were advised by SCN that a s47 certificate will be issued by the CP where appropriate.

Rights and restrictions

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 an individual is made a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, one person was specified under the Mental Health Act. We reviewed the care records of this individual and found that the appropriate paperwork had not been completed in relation to restrictions around telephone use (RES 3), and there was no reasoned opinion recorded when decisions were made to impose restrictions.

Recommendation 2:
Medical staff responsible for Rutherford Ward should ensure appropriate paperwork is completed in relation to all restrictions applied to individuals specified under the Mental Health Act.

We also found that the individual was not provided with written information regarding restrictions, including information about the review process and their rights in relation to appeal. We discussed these issues with the SCN and SM on the day of our visit and were advised that training and guidance has been issued to staff regarding specified person and that concerns would be escalated to CP for action.

Recommendation 3:
Medical staff responsible for Rutherford Ward should ensure a reasoned opinion is provided in relation to all restrictions applied to individuals specified under the Mental Health Act.

Recommendation 4:
When someone is made a specified person, medical staff should provide individuals with written information regarding restrictions imposed, timescales for review and information about their rights.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[1].

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 did not find any copies of advanced statements but were advised that information on writing an advance statement is provided by ward staff and supported by advocacy services.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

One-to-one and group-based activities in Rutherford Ward were provided by the PAC nurse, OT, physiotherapy and voluntary service co-ordinator. We heard from individuals that we met with that they enjoyed the range of activities, including Tai Chi, access to a gym, music and art groups as well as pet therapy.

Some of the individuals we met with and/or reviewed care records of were receiving assessment and input from OT services, including a functional assessment to support future discharge from hospital.

The physical environment

Rutherford Ward is a spacious and bright environment that provided individuals with single en-suite bedrooms. The ward was clean, with several seating areas, a therapeutic activity room, and a large separate dining area.

Individuals could also access a well-maintained garden area that was enclosed to ensure safety.

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Summary of recommendations

Recommendation 1:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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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