Mental Welfare Commission for Scotland

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

Date of visit: 30 April 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Tate Ward is a 20-bedded unit that provides mental health care and treatment for adults between 18 and 65 years of age. On the day of our visit, one room was vacant due to a flooding incident, and we were advised the room was due to be repaired.

On the day of our visit, there were 19 people on the ward, and no vacant beds.

We last visited this service in February 2023 on an announced visit and made recommendations regarding person-centred care planning, administration of medication, availability of meaningful activities, privacy of individuals and health safety issues relating to the environment.

The response we received from the service was that auditing and staff supervision was being carried out to improve person-centred care plans as well authorisation and administration of medication. We were also informed that a patient activity co-ordinator (PAC) nurse was now in post and work had been undertaken in the environment to improve privacy and the safety of individuals.

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

Who we met with

We met with five people and reviewed the care records of six people. We also met with two relatives.

In addition, we joined a newspaper group which was attended by three individuals.

We spoke with the charge nurse (CN), two bank nurses (BN), the PAC nurse and the inpatient team manager support nurse.

Following our visit, we made follow up enquiries with the senior charge nurse (SCN), the consultant psychiatrist (CP), the service manager (SM) and the operational lead nurse.

Commission visitors

Gemma Maguire, social work officer

Denise McLellan, nursing officer

What people told us and what we found

Individuals we met with told us that staff were “helpful” and “reassuring”. We also heard that people thought the service had “really helped” their recovery and that they met with the nurses and doctors regularly.

Relatives we met with told us that their loved ones were being “well looked after” by the service and that they were provided with “good” information about the person’s care and treatment.

We met with the PAC nurse who had been appointed to the post since the time of our last visit. We were impressed with their dedication and enthusiasm, and we pleased to hear that they had helped to develop meaningful one-to-ones and/or group-based activities for individuals. We were invited to attend a newspaper group facilitated by the PAC nurse and found decisions on news topic were led by individuals. People we met with told us the PAC nurse was “great”.

Some individuals we met with choose not to use the PAC nurse service and reported they felt “bored” being in hospital. For these individuals, we were pleased to find that consultation between PAC nurse, occupational therapy and named nurses ensured that meaningful activity programs were in place, with group activities continuing to be offered.

When we first arrived on the ward we were welcomed by a bank nurse (BN) and the PAC nurse. We were advised there was no charge nurse (CN) on shift that morning, but the ward was fully staffed. The BN alerted managers to our visit, and we were able to meet with CN and operational support manager in the afternoon as the SM, SCN and operational lead were on leave. We heard from two nurses who have retired and now work as BNs, that “it’s a great ward to work in”.

We were also pleased to report that during this visit, improvements had been made to the environment. This included the use of window screens in two of the ensuite bedrooms, which now ensured privacy for individuals being admitted to these bedrooms. The service has also installed a convex mirror in the main corridor of the ward, ensuring staff could have appropriate supervision of the ward.

Most people we met with on the day of our visit had been admitted to hospital for less than six months. Two individuals had been in hospital for over one year and were in the process of being discharged, with involvement from occupational therapy (OT), social work and care providers to support and progress the discharge plans.

Care, treatment, support, and participation

Care records

All care records, including care plans, multidisciplinary team (MDT) records and risk assessments were accessible on the electronic recording system, EMIS.

We found that care plans and reviews were being updated, with good information about the person's progress in their recovery. While we noted that some individuals' views were recorded in care plans, this was inconsistent and some care plans had not recorded views of family, despite them being actively involved.

Individuals can consent to information being shared with family and where they do not this should be respected by staff. However, the Commission are of the view that where family and/or carers are involved, services should listen to their views and document them, even if information cannot be shared with them about their loved one.

Of the individuals we met with, many were not aware of and/or had not seen a care plan document but they did appear to understand their individual goals. We found the language used in some care plans was nursing-orientated as opposed to being led by the person. We discussed the issues around person-centred care planning with the CN on the day of our visit and were advised that our feedback will be considered as part of the ward's audit processes.

Recommendation 1:
Managers responsible for Tate Ward should carry out an audit of person-centred care plans to ensure they use individualised language, are accessible to individuals and that the views of individuals and their families clearly recorded.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

We found individuals had risk assessment documents in place however there were inconsistencies with documented information in relation to assessed risks and how staff should manage these risks. For example, we reviewed the care records of one individual who had been subject to procedures of the Adult Support and Protection (Scotland) Act, 2007 (ASP Act) following an incident which placed them at significant risk of harm during time out of the ward.

We found information in the MDT meeting, as well as an ASP review case conference minute, which discussed how these risks should have been managed by ward staff. However, this information was not reflected in in the risk assessment

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

documents. When discussing this with staff, they appeared unclear about how they should manage these specific risks.

We also found that one person's risk assessment document had not been updated to reflect a change in their time out of the ward, which had been agreed at an MDT meeting.

We fed these issues back to the CN on the day of our visit who assured us that both individual risk assessment documents, as well as person-centred care plans, would be reviewed and updated. We will continue to follow up on these individual issues.

Recommendation 2:
Managers responsible for Tate Ward should audit risk assessment documentation to ensure they are reviewed, with information provided on how each risk should be managed.

Multidisciplinary team (MDT)
The multidisciplinary team (MDT) for Tate Ward consists of nursing staff, consultant psychiatrists (CPs), junior doctors, OT and psychology. Referrals can also be made to other services, such as speech and language therapy.

MDT meetings continue to take place weekly, with detailed notes of who attended the meeting and clear action points relating to person-centred care plans. We also found that individuals and/or their family were invited to attend meetings and their views were recorded.

Use of mental health and incapacity legislation

On the day of the visit, 10 people in Tate Ward 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, 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) had an accompanying consent form with the person's signature, however, we noted that medication prescribed on one individual's T2 certificate was listed as a drug class instead of identifying the specific medication. Best practice is to specify the actual medications and their purpose on the T2 certificate.

We found one person did not have prescribed medication on a certificate authorising their treatment (T3) under the Mental Health Act. We fed back on these concerns to the CN for them to action on the day of our visit.

Recommendation 3:
Medical staff in Tate Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

Any person 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 the documentation to be accessible and that the named person had been appropriately consulted.

We met with and reviewed the care records of one person who was subject to the Adults with Incapacity (Scotland) Act, 2000 (AWI Act). We found that care records had clear and accessible information on welfare and financial decisions that were being managed under the AWI Act. We also found that CPs were appropriately assessing the capacity of two individuals in relation to specific welfare and/or financial decisions and were consulting with the individuals, their families and social work.

We were pleased to find an example of good practice in relation to the process of reviewing 'do not attempt cardiopulmonary resuscitation' (DNACPR) for one individual. The DNACPR had been put in place by a medical doctor prior to the person being admitted Tate Ward. When reviewing the DNACPR, the CP was considering the views of the individual, as well as their family appropriately and this was clearly recorded.

When asking nursing staff about individuals who were subject to the AWI Act, we found they were unaware of specific powers in place, despite this information being available in care records. We provided advice to managers on the day of our visit to ensure staff are aware of relevant AWI Act powers in place for individuals they are supporting. We also shared details of learning resources developed by the Commission and NHS Education for Scotland.

Recommendation 4:
Managers responsible for Tate Ward should ensure that nursing staff are familiar with the AWI Act and are aware of relevant powers that are in place for the individuals they support.

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 individuals we reviewed who were subject to a section 47 certificate, we found these to be appropriately in place.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is 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, two people in Tate Ward were specified under the Mental Health Act. We reviewed the care records for both these individuals and found that there was no reasoned opinion recorded in restrictions imposed.

We also found that the appropriate notification paperwork had not been completed by the CP in relation to telephone restrictions (RES 3). Additionally, individuals had not been notified in writing about the restrictions that were in place, or review timescales in relation to their rights. In discussion with nursing staff, they reported to be unclear of what restrictions individuals had in place and how these should be implemented.

We discussed these issues with the CN on the day of our visit and wrote to the service requesting action is taken in relation to individuals who are specified. We will continue to follow up on these issues.

Recommendation 5:
When someone is made a specified person, medical staff in Tate Ward should ensure appropriate notification paperwork is completed in relation to restrictions being implemented and record a reasoned opinion for imposing restrictions. Individuals should also be given written information regarding restrictions in place, timescales for review and information about their rights.

Recommendation 6:
Managers responsible for Tate Ward should ensure that when someone is made a specified person, nursing staff are aware of restrictions in place and how they should implement restrictions.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

Some people we met with on Tate Ward were admitted on an informal basis, and could leave the ward, and hospital grounds, if they chose to do so. Some individuals who were admitted informally had 'pass plans' in place which is an agreed plan between the MDT and the individual regarding time out of the ward and/or hospital.

The Commission accepts that for some individuals, such plans can form part of the recommended treatment and may be appropriate if the individual understands their

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

rights and is able to fully consent. However, the views expressed by some individuals that we spoke with suggested this has not been understood. While these individuals had agreed to admission, and wanted to remain in hospital, some believed they could not leave without staff permission.

One person reported to be unaware of the exit door code to the ward. We raised this issue with CN on the day of our visit who agreed to write the door code down for the individual.

The care records we reviewed did have information about 'pass plans', but we did not see the detailed discussions and/or recorded consent from individuals that we would have expected. We discussed this with the CN on the day of our visit and were advised that individualised 'pass plans' are agreed verbally with individuals. We advised the service that information should be provided to individuals verbally and in writing, to ensure their rights are clearly understood.

Recommendation 7:
Managers should ensure individuals who are admitted informally to Tate Ward are fully advised of their rights, verbally and in writing. They should check individuals understand their rights when being asked to consent to recommended treatment, including being advised not to leave the ward/hospital.

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. Where individuals had an advance statement in place, the electronic system provided an alert to ensure staff reviewing the records were aware. We found some evidence that advance statements were being discussed within MDT meetings, but this was not consistent. In discussion with the CN, we were advised that nursing staff and advocacy services support individuals to complete an advance statement whenever appropriate to do so.

The Commission has developed *Rights in Mind.*[3] 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

Since our last visit, the service has developed a PAC nurse role which supports group based and one to one activity for individuals. Group activities include current affairs, walking, music and relaxation. Many individuals were also being supported by OT

[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

services, with functional assessments being carried out to support discharge planning.

Some individuals were being encouraged to engage with community resources such as ‘restart’ which provided a recovery-focused program to develop vocational skills.

The ward dining area had a variety of activity information on display, including access to beauty treatments, information about the community hub (which was located in the main Gartnavel Royal Hospital building). Themed events were also taking place on the ward, including mental health awareness week.

We were also pleased to find that care records evidenced evaluation of individual activity.

The physical environment

As we have previously commented that Tate Ward is not located with other acute adult admission services in the main Gartnavel Royal Hospital. During this visit we heard how staff, individuals and family feel this is “unfair” given the main building is purpose built, with a much fresher and modern appearance, as well has having closer access to the community hub.

We have been advised by the service that major structural work would be required to bring Tate Ward up to the same specification as wards in the main building.

On the day of our visit, we observed individuals smoking in the communal garden area. The Commission are aware that the law has changed, and it is not lawful for anyone to smoke in hospital grounds in Scotland. We were informed that individuals are advised not to smoke on hospital grounds and that nicotine replacement therapy (NRT) is available, however some people continue to smoke in the areas outside the wards.

The Commission is clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While the Commission understands that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other inpatient services are enforcing smoking bans and utilised NRT.

Recommendation 8:
Managers responsible for Tate Ward should ensure that legislation and local procedures are adhered to in relation hospital buildings being smoke free.

Summary of recommendations

Recommendation 1:
Managers responsible for Tate Ward should carry out an audit of person-centred care plans to ensure they use individualised language, are accessible to individuals and that the views of individuals and their families clearly recorded.

Recommendation 2:
Managers responsible for Tate Ward should audit risk assessment documentation to ensure they are reviewed, with information provided on how each risk should be managed.

Recommendation 3:
Medical staff in Tate Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

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Recommendation 8:
Managers responsible for Tate Ward should ensure that legislation and local procedures are adhered to in relation hospital buildings being smoke free.

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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