AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26 September 2022**
Report By:	**Kate Rocks Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/39/2022/AM**
Contact Officer:	**Anne Malarkey Head of Mental Health Homelessness and ADRS**	**Contact No:**	**01475 715284**
Subject:	**Mental Welfare Commission Local Visits 2021**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 The purpose of this report is to share with Inverclyde IJB a report produced by NHS GGC which details the findings from the Mental Welfare Commission Local Visits to mental health inpatient wards in Greater Glasgow and Clyde, published during the period 1st January 2021 to 31st December 2021.

1.3 The Mental Welfare Commission undertake local visits, either announced or unannounced; and visit a group of people in a hospital, care home or prison service. The local visits identify whether individual care, treatment and support is in line with the law and good practice; challenge service providers to deliver best practice in mental health, dementia and learning disability; follow up on individual cases where the Commission have concerns, and may investigate further; and provide information, advice and guidance to people they meet with.

1.4 During local visits the Mental Welfare Commission review the care and treatment of patients, meet with people who use the service; and also speak to staff and visitors.

1.5 Local Visits are not inspections; and the Mental Welfare Commission's report details findings from the date of the visit.

1.6 The Mental Welfare Commission provides recommendations and the service is required to provide an action plan response within three months, providing detail of the actions and timescales for completion.

1.7 The Mental Welfare Commission published 20 Local Visit Reports during the reporting period.

1.8 The Mental Welfare Commission visited adult inpatient wards; older adult inpatient wards, intensive psychiatric care units (IPCU); and rehabilitation wards. Of the 20 local visits all were

announced but one was undertaken on a virtual basis. A total of 73 recommendations were made. All 4 out of the 5 mental health inpatient wards within Inverclyde were visited is the time period of the report.

1.9 Details of the reports which received recommendations are outlined in paragraph 4.4 of main report; and the services' response are detailed at Appendix 1.

2.0 RECOMMENDATIONS

2.1 The Integrated Joint Board is asked

a) Note the content of the report particularly in relation to inpatient services within Inverclyde HSCP; and
b) Note the recommendations of the Mental Welfare Commission and the services' response at Appendix 1.

3.0 BACKGROUND AND CONTEXT

3.1 When local visits are undertaken the Commission look at:

- Care, treatment, support and participation;
- Use of mental health and incapacity legislation;
- Rights and restrictions;
- Therapeutic activity and occupation; and
- The physical environment.

4.0 PROPOSALS

4.1

a. Note the content of the report particularly in relation to inpatient services within Inverclyde HSCP; and
b. Note the recommendations of the Mental Welfare Commission and the services' response at Appendix 1.

5.0 IMPLICATIONS

Finance

5.1 One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

Legal

5.2 None

Human Resources

5.3 None

5.4 **Equalities**

None

(a) Equalities

This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

	YES – Assessed as relevant and an EqIA is required.
x	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required. Provide any other relevant reasons why an EqIA is not necessary/screening statement.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

NATIONAL WELLBEING OUTCOMES

5.6 How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None

Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	None

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 None

8.0 BACKGROUND PAPERS

8.1 None

Appendix 1

Item No. 13

Meeting Date **Wednesday 13th April 2022**

Glasgow City Integration Joint Board Finance, Audit and Scrutiny Committee

Report By: **Dr Martin Culshaw, Deputy Medical Director, Mental Health Services and Addictions**
Jackie Kerr, Assistant Chief Officer, Adult Services

Contact: **Jackie Kerr**

Phone: **0141 314 6250**

Mental Welfare Commission Local Visits 2021

Purpose of Report:	The purpose of this report is to present to the IJB Finance, Audit and Scrutiny Committee the findings from the Mental Welfare Commission Local Visits to mental health inpatient wards in Greater Glasgow and Clyde, published during the period 1st January 2021 to 31st December 2021.

Background/Engagement:	The Mental Welfare Commission was originally set up in 1960 under the Mental Health Act. Their duties are set out in current Mental Health Care and Treatment Act. The Commission carry out their statutory duties by focusing on five main areas of work. They have a programme of visits to services who deliver Mental Health Care and Treatment to assess practice, monitor the implementation of mental health legislation, investigations, offering information and advice, and influencing and challenging service providers. The Mental Welfare Commission undertake local visits, either announced or unannounced; and visit a group of people in a hospital, care home or prison service. The local visits identify whether individual care, treatment and support is in line with the law and good practice; challenge service providers to deliver best practice in mental health, dementia and learning disability; follow up on individual cases where the Commission have concerns, and may investigate further; and provide

	information, advice and guidance to people they meet with.

Governance Route:	This paper has been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☐ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☒ (please note below) Mental Health Services Clinical Governance Group; and reporting arrangements as detailed at Section 6 of the report. Not Applicable ☐

Recommendations:	The IJB Finance, Audit and Scrutiny Committee is asked to: a) Note the contents of the report; and b) Note the recommendations of the Mental Welfare Commission and the Services' response at Appendix 1.

Relevance to Integration Joint Board Strategic Plan:
These services are integral to the IJB's strategy for delivering high quality care and effective outcomes for the city's most vulnerable adults and older people.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	This report relates to outcomes 3, 4 and 7.

Personnel:	None

Carers:	The Mental Welfare Commission engage with carers' and relatives during the Local Visit.

Provider Organisations:	None

Equalities:	None

Fairer Scotland Compliance:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	Poor Local Visits may mean that people are not receiving good quality care and outcomes. There are also reputation risks to the Health and Social Care Partnership as the local visit reports are published on the Mental Welfare Commission website.

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	Mental Welfare Commission recommendations for in-patient services managed by NHS Greater Glasgow and Clyde / Health and Social Care Partnerships have a direct impact on the public perception of NHS Greater Glasgow and Clyde; and subsequently the Health and Social Care Partnerships. The report confirms detailed action plan responses to the recommendations of the Mental Welfare Commission.

1. Purpose

1.1 The purpose of this report is to present to the IJB Finance, Audit and Scrutiny Committee the findings from the Mental Welfare Commission Local Visits to mental health inpatient wards in Greater Glasgow and Clyde, published during the period 1st January 2021 to 31st December 2021.

2. Background

2.1 The Mental Welfare Commission undertake local visits, either announced or unannounced; and visit a group of people in a hospital, care home or prison service. The local visits identify whether individual care, treatment and support is in line with the law and good practice; challenge service providers to deliver best practice in mental health, dementia and learning disability; follow up on individual cases where the Commission have concerns, and may investigate further; and provide information, advice and guidance to people they meet with.

3. Process

3.1 During local visits the Mental Welfare Commission review the care and treatment of patients, meet with people who use the service; and also speak to staff and visitors.

3.2 Local Visits are not inspections; and the Mental Welfare Commission's report details findings from the date of the visit.

3.3 The Mental Welfare Commission provides recommendations and the service is required to provide an action plan response within three months, providing detail of the actions and timescales for completion.

4. Local Visits Reports 2021

4.1 The Mental Welfare Commission published 20 Local Visit Reports during the reporting period.

4.2 The Mental Welfare Commission visited adult inpatient wards; older adult inpatient wards, intensive psychiatric care units (IPCU); and rehabilitation wards. Of the 20 local visits all were announced but one was undertaken on a virtual basis. A total of 73 recommendations were made.

4.3 There were no recommendations made following local visits to:

- Intensive Psychiatric Care Unit, Gartnavel Royal Hospital on 13th May 2021; and
- Munro Ward, Stobhill Hospital (Adult Acute) on 8th June 2021 (virtual).

4.4 Details of the reports which received recommendations are outlined in the undernoted table; and the services' response are detailed at Appendix 1 which are accessible by selecting the page number:

	Mental Welfare Commission Local Visit	Date of Visit	Action Plan
1.	Kelvin House, Gartnavel Royal Hospital Rehabilitation Ward	12th November 2020	Page 11
2.	Rehabilitation Ward, Leverndale Hospital Rehabilitation Ward	15th December 2020	Page 13
3.	Timbury Ward, Gartnavel Royal Hospital Older People Mental Health (functional)	5th May 2021	Page 14
4.	Ward 2, Leverndale Hospital Adult Continuing Care	13th May 2021	Page 17
5.	Clyde House, Gartnavel Royal Hospital Rehabilitation Ward	18th May 2021	Page 19
6.	Tate Ward, Gartnavel Royal Hospital Adult Acute	18th May 2021	Page 21
7.	Oak Ward, Inverclyde Hospital Adult Continuing Care	8th June 2021	Page 24
8.	Arran Ward, Dykebar Hospital Rehabilitation Ward	21st June 2021	Page 25
9.	IPCU, Leverndale Hospital Intensive Psychiatric Care Unit	22nd June 2021	Page 28
10.	Isla Ward, Stobhill Hospital Older People Mental Health (functional)	23rd June 2021	Page 29
11.	Ailsa Ward, Stobhill Hospital Rehabilitation Ward	29th June 2021	Page 30

12.	Fruin & Katrine, Vale of Leven Hospital Older People Mental Health (organic and functional)	30th June 2021	Page 31
13.	Ward 37, Royal Alexandria Hospital Older People Mental Health (organic)	8th July 2021	Page 32
14.	Langhill Clinic, Inverclyde Royal Hospital Adult Acute and Intensive Psychiatric Care Unit	12th July 2021	Page 36
15.	Wards 4 A & B, Larkfield Unit, Inverclyde Royal Hospital Older People Mental Health (organic and functional)	24th August 2021	Page 39
16.	Ward 39, Royal Alexandria Hospital Older People Mental Health (functional)	31st August 2021	Page 42
17.	Cuthbertson Ward, Gartnavel Royal Hospital Older People Mental Health (organic)	7th October 2021	Page 42
18.	Banff Ward, Leverndale Hospital Older People Mental Health (functional)	3rd November 2021	Page 43

4.5 The undernoted local visits also took place in 2021; reports will be published in 2022 and included in the next annual report:

- 19/10/2021 - Claythorn House, Gartnavel Royal Hospital (Learning Disability Services)
- 03/11/2021 - Netherton Unit, Glasgow (Learning Disability Services)
- 10/11/2021 - North Ward, Dykebar Hospital (Older People Mental Health complex care)
- 16/11/2021 - Ward 4, National Child Psychiatric Inpatient Unit, Royal Hospital for Children
- 26/11/2021 - Blythswood House, Renfrew (Learning Disability Services)
- 29/11/2021 - Mother and Baby Unit, Leverndale Hospital
- 30/11/2021 – Glenarn Ward, Dumbarton Joint Hospital (Older People Mental Health complex care)
- 09/12/2021 - Rowanbank Clinic, Stobhill Hospital (Forensic)
- 14/12/2021 - Willow Ward, Orchard View, Inverclyde (Older People Mental Health complex care)

5. Recommendations and Good Practice

5.1 When local visits are undertaken the Commission look at:

- Care, treatment, support and participation;
- Use of mental health and incapacity legislation;
- Rights and restrictions;
- Therapeutic activity and occupation; and
- The physical environment.

5.2 Issues identified from the recommendations were in relation to:

5.2.1 **Care, Treatment, Support and Participation:**

- Care Plans – ensuring consistency in the quality; better evidencing patient involvement; identifying clear interventions and care goals; reflecting holistic needs of patients; including triggers and de-escalation strategies for those who experience stress and distress; ensuring plans are regularly reviewed and audited; and that legal status is recorded in care plans.

- Multi-disciplinary Team Meeting Notes – some lacking in detail around decisions taken, actions required and future plans.
- Getting to Know Me Forms – to ensure that these are fully completed and follow the patient when they move to another care setting.
- DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) Forms – not all were renewed within timescales and all staff were not completely aware of the status of every patient.
- Engagement with Carers and Relatives – to introduce processes for meaningful engagement; there was little evidence of family involvement and there was no formal engagement process or carers group.
- Long Stay Patients in IPCU – concerns reported at the length of stay of a small number of patients within two IPCU sites.
- Psychology and Psychological Therapy – lack of provision within IPCU and access should be improved.

5.2.2 **Use of Mental Health and Incapacity Legislation:**

- Copies of powers of guardianship under the AWI Act and proxy decision maker were not always available on the ward.
- Treatment under the Mental Health Act – some omissions reported of regular prescribed medication not being appropriately authorised on T2 and T3 treatment forms; and that a system of auditing compliance should be put in place.
- Advanced Statements should be promoted on the ward and discussions with the patient clearly recorded in the care plan.
- Lack of understanding of the use of the legislation of the Specified Persons Procedure and little evidence of review or application.

5.2.3 **Rights and Restrictions:**

- To maximise visiting arrangements for patients and ensure that patients are supported to use technology to maintain contact with relatives and carers.
- To ensure that advocacy services are available to patients and that information is displayed in the ward.

5.2.4 **Therapeutic Activity and Occupation:**

- Ensure that activity provision meets the individual needs and preferences of patients.
- Ensure optimal access to specialist occupational therapy lead assessments and dedicated therapeutic activity provision.

5.2.5 **The Physical Environment:**

- Ventilation and temperature to be reviewed in some wards to achieve comfort and health and safety for staff and patients; and to allow use of the therapeutic kitchen.
- Management to consider the introduction of single room accommodation, where this is not in place; and also assessment of ward layout to reduce ligature risk.
- Refurbishment work to be undertaken to create a welcoming environment that is fit for purpose.
- Some environmental issues reported in relation to Wi-Fi and TV signal connection; toilet flush system and laundry service.

5.3 **Good Practice**

The Mental Welfare Commission may also include in their report good practice noted at the visit. Examples of good practice from the reports published in 2021 included:

- The efforts of the Senior Charge Nurse to ensure all staff had professional input to enhance the care and treatment they provide, such as training in psychosocial inventions, physical healthcare, and autistic spectrum disorder. *(Kelvin House, Gartnavel Royal Hospital)*
- Nursing staff playing an active role in supporting colleagues in the adult mental health wards on the hospital site; by providing an outreach model with assistance from the Scottish Patient Safety Programme, this reduced the number of admissions to IPCU. *(IPCU, Leverndale Hospital)*
- The level of detail and the quality of information within the chronological nursing notes; these contained detailed information around the individual's mental and emotional state on a daily basis and what may be affecting this. *(Fruin and Katrine, Vale of Leven Hospital)*
- The impact of the dedicated therapeutic activity nurse role within the ward; enabling the ward to continue to maintain a level of activity provision throughout the pandemic. *(Isla Ward, Stobhill Hospital)*

5.4 The Commission also acknowledged the efforts of staff during the Covid19 pandemic and supporting patients; and of the collaboration, commitment and creativity in finding new ways of working. Staff ensured the continued delivery of therapeutic, social and recreational activities for patients; and also prioritised family and carer contact through remote visiting and the use of telephone and tablet devices.

6. Governance Arrangements and Shared Learning

6.1 Governance arrangements are in place to ensure the robust monitoring of the Local Visit Reports. A summary report is presented to the monthly Mental Health Services Clinical Governance Group; and any significant issues are highlighted immediately to the Deputy Medical Director, Mental Health Services and Addictions, the local Clinical Director and Head of Service for review. A summary of Local Visits are also included in the Deputy Medical Director's bi-monthly Governance Lead Update to the Health Board Clinical Governance Forum.

6.2 A quarterly report is presented to the Adult Services Clinical Governance Group and the Glasgow City Integrated Clinical and Professional Governance Group to ensure cross system learning in relation to the recommendations made and the service response. Examples of good practice are also shared with the group. This report is available for HSCPs in GG&C to share at their governance forums; as well as the annual report produced for this Committee.

6.3 Where themes emerge consideration is given in relation to quality improvement work that is required. The Mental Health Quality Improvement Sub Group identify areas which require improvement through the analysis of data, themes and trends. Actions may include the use of the 7 Minute Briefing learning tool, for example, on the Specified Person's Procedure and

treatment forms for use under the Mental Health Act; and may also undertake audits, prompts and checks; for example, for care plans and treatment forms.

7. Service Improvements

7.1 Boardwide service improvement work is ongoing in relation to some of the issues noted in the recommendations. Progress is outlined below:

7.1.1 Care Plans

The work around person centred care planning has been difficult to progress due the Covid 19 pandemic. During that time however we gathered examples of person centred care across our service and are working with Health Improvement Scotland's Dementia Collaborative to develop our person centred care planning in our Specialist Dementia Wards.

This year we have updated our key areas for development and identified a Senior Nurse who will be responsible for driving our Person Centred Work over the coming year.

In 2021 Mental Health Staff participated in a scoping exercise across NHS GG&C to gain an overview of Person Centred Care practice, and we will utilise this learning for future developments and plans. We have also been reviewing how we undertake and standardise Person Centred Care Planning across Mental Health Services and have been considering how this can be created into an electronic format on our IT System.

We have revised our Nursing Audit content and system so we can measure Person Centred Care Planning at ward and community team level. We know that care planning practice is variable, so this year will provide training and good practice examples to improve, promote and develop staff's competency in this area.

Strategic planning is now very recently recommenced and we will work with the Person Centred Strategic Group who have set out key principles for Person Centred Care Planning across NHS GG&C. We will operationalise these principles into our local plan and work with service user representatives to ensure they have opportunity to contribute to our plans.

7.1.2 Treatment Forms

Professional Nurse Leads have undertaken a prescription audit for T2/T3 compliance within inpatient sites. An action plan has been developed and is being implemented. The audit had identified some practice issues, there is no systemic issue of risk/non-compliance. The Acting Chief Nurse and Policy Sub Group are also reviewing the policy 'NHS GG&C Mental Health Service Mental Health (Care & Treatment) (Scotland) Act 2003 Policy for Treatment with Medication after 2 months'; and a 7 Minute Briefing is being developed as learning tool on treatment forms for use under the Mental Health Act.

7.1.3 Hospital Electronic Prescribing and Medicines Administration (HEPMA)

This is a new digital system which is replacing the paper drug chart (Kardex) for inpatient areas across NHS GG&C. Clinicians have been involved in shaping the system and this will be implemented across Mental Health Services from Spring 2022.

7.1.4 EMISWeb Health Care System

The functionality of EMISWeb continues to be improved. An EMIS alert for DNACPR forms (Do Not Attempt Cardiopulmonary Resuscitation) has been included and the necessary measures to be taken are specified.

7.1.5 Clinical Risk Assessment Framework for Teams

The Clinical Risk Assessment Framework for Teams (CRAFT) is the NHS GG&C risk assessment template used across all mental health services. CRAFT was launched in October 2019 and is completed electronically, alongside the patient's electronic case records. It is complemented by mandatory face-to-face clinical risk training for all clinical teams.

7.1.6 Missing Person Policy; and Safe and Supportive Observation Policy and Practice Guidance

The Mental Health Services Missing Persons Policy was published on the 2nd July 2021 and staff training provided. The Mental Health Services Safe and Supportive Observation Policy and Practice Guidance review is complete. The Policy Implementation Group will oversee the roll out of the policy and agreed training.

7.1.7 Suicide Prevention and Design Standards Group

The Suicide Risk and Design Standards Group have oversight of ligature risk reduction agenda within NHS GG&C. The current programme of work undertaken by the group includes:

- have identified, via assessment of previous incidents and use of environmental checklists, the highest risk areas and began a schedule of survey work to price improvements to reduce ligature risk in those areas. This is nearing completion and will provide oversight on phased costs;
- seeking consistency in procurement/ estates processes;
- exploring the development of training programmes for staff groups;
- reinvigorating the use of Safety Action Notices for Mental Health Services;
- development of a policy - NHS GG&C Suicide Reduction and the Management of Ligature Risks Policy, which has been considered by the Health Board Corporate Management Team and governance groups; and will be circulated in coming weeks via the Communications team.
- established a sub group, led by acute colleagues and supported by the mental health group, to focus on this agenda in acute sites following recent incidents on sites.

7.1.8 Workforce Model

There are a high number of medical and nursing staff pressures across Mental Health Services. The workforce plan for Adult Nursing Services is being scoped out and will be developed; future staffing models, recruitment, retention and staff development is being considered. The scope of the medical workforce is also being explored and the workforce strategy is being updated.

7.1.9 Advanced Statements

The NHS GG&C policy on Advanced Statements highlights the need to raise awareness of advanced statements with patients on an ongoing basis, and to encourage patients to consider making one. There are leaflets available in in-patient areas and online resources that patients *(and carers / Named Person)* can be signposted to. The NHS GG&C Legislation Sub Group, short life working group will look at improving practice; consider further practice developments and take account of the good practice initiatives currently in place to improve pathways.

8. Recommendations

8.1. The IJB Finance, Audit and Scrutiny Committee is asked to:

a) Note the content of the report; and
b) Note the recommendations of the Mental Welfare Commission and the services' response at Appendix 1.

Appendix 1

Date of Visit	Local Visit	Local Visit Recommendation	Action Plan Response to Recommendation	Timescale	Update
12/11/2020	Kelvin House, Gartnavel Royal Hospital	1. Managers should ensure there is consistency in the quality of the care plans, that they better evidence patient involvement and are regularly reviewed.	There is now a system in place to ensure that all needs statements reflect the individual and although the needs statement are reviewed at each Multi-disciplinary Team this is not always reflected in the EMIS updates. The Senior Charge Nurse has discussed this with all disciplines and this is now audited on a monthly basis and on ad hoc basis x 2 patients weekly by the Senior Charge Nurse.	Completed	Audits ongoing but staffing consistency a major issue due to high levels of unpredicted absence. Practice Development Nurse to undertake audit early 2022 as marker.
12/11/2020	Kelvin House, Gartnavel Royal Hospital	2. Managers should review the adequacy, safety and effectiveness of the ventilation within the therapy kitchen.	This was being addressed well in advance of the MWC visit and has been on our agenda for some period of time which somewhat answers the point about the adequacy of the system. It is inadequate. Delays have been brought about by a variety of matters including proposed significant refurbishment which fell through. We contacted Operational Estates in July 2020 and asked them to obtain quotes to progress the work. We still wait for this to be advanced by them with the pandemic clearly impacting on this. This will continue to be pursued with vigour and addressed as soon as Operational Estates can organise the work.	As soon as is practicable.	Requests submitted to Operational Estates who have not advanced work or submitted timeframe. Operations Coordinator is in ongoing contact with them to try and obtain a schedule of works. Changes in personnel within Operational

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Date of Visit	Local Visit	Local Visit Recommendation	Action Plan Response to Recommendation	Timescale	Update
					Estates has not assisted matters. Will escalate to Head of Service if no schedule is forthcoming.
12/11/2020	Kelvin House, Gartnavel Royal Hospital	3. Managers should review the adequacy and safety of the treatment room and the current need to perform all physical health procedures in the patient's bed.	This has been discussed fully with the ward management team and all (limited) options explored on numerous occasions. The preferred option for the clinical and Hospital Management Teams is a significant refurbishment and extension of current facility to include single ensuite bedrooms as per the findings of GG&C Rehabilitation Review. With regards to the current adequacy and safety of the treatment room it meets the basic medication needs of the ward as it is a goal/expectation that self-medication be achieved by the service user. Given this it is adequate and safe. We presented to the ward team an option to develop a room at the side entrance of the ward and make this a larger treatment room which would accommodate an examination couch and retain the current treatment room for routine medication work though they felt this would not offer them anything given the remote location of the room. This is the only room which could be reasonably adapted and if the clinical team change their mind this will be progressed. The ward management team would like to progress (further) the rehabilitation	Will be kept under review.	The clinical team and indeed Hospital Management Team feel the treatment room is safe if not optimal for practice. The basic ward design does not lend itself to radical action. The ward team were presented with option to re-site the Treatment Room and declined these. These remain open to them if they change their mind.

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Date of Visit	Local Visit	Local Visit Recommendation	Action Plan Response to Recommendation	Timescale	Update
			ethos and promote attendance by the service user at GP surgeries, when appropriate, in the future.		
15/12/2020	Rehabilitation Ward, Leverndale Hospital	1. Managers should ensure that advance statements are promoted in the ward and clearly documented in the patient's pathway and care plan.	Ongoing discussion with patients within their combined support plans regarding advanced statements. Recording patients own thoughts and feelings. Ongoing audit to ensure process is being adhered to.	April 2021	Named Nurse conversations with patients within Rehab discuss advance statements.
15/12/2020	Rehabilitation Ward, Leverndale Hospital	2. Managers should ensure that the ward environment is upgraded to create a conducive setting and that consideration be given to single room accommodation.	Rehabilitation services currently under review, consideration will always be given to single room accommodation. Ongoing assessment to ensure that area is conducive to recovery.	Ongoing consideration.	Ongoing consideration. Some cosmetic works to update fabric and furnishings have been carried out.
15/12/2020	Rehabilitation Ward, Leverndale Hospital	3. Managers should ensure that assessments of the ward layout, particularly with regards to difficult to observe areas and ligature points, are actioned.	Self-harm environmental checklists completed highlighting areas of risk. This is risk assessed and if high risk actioned immediately.	Ongoing assessment of environmental risk	Reviewed as per board policy on Self Harm Checklist. Project Manager to be appointed to support all Ward areas and Hospitals for

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Date of Visit	Local Visit	Local Visit Recommendation	Action Plan Response to Recommendation	Timescale	Update
					uniformity of approach.
05/05/2021	Timbury Ward, Gartnavel Royal Hospital	1. Managers should ensure that MDT meeting notes contain details of current issues and presentation, decisions taken, actions required and future plans in relation to the care goals, treatment and discharge of patients, and this should be audited to ensure consistent quality of record keeping.	• The ward uses the standardised Multi-disciplinary Team (MDT) sheet on EMIS which is the mechanism for capturing the details listed in the recommendation. • Nursing Team will instigate a pre-MDT huddle to explore goals and problem areas. • Senior Charge Nurse (SCN) will undertake monthly audit of MDT sheets to confirm quality assurance and to identify areas of development.	3 months	Audits ongoing and Senior Charge Nurse meets with Hospital Management Team to review findings. Improvement still required and once staffing stabilises this will be easier to implement and monitor.
05/05/2021	Timbury Ward, Gartnavel Royal Hospital	2. Managers should ensure nursing care plans identify clear interventions and care goals to support discharge planning, and set out review timescales, and this should be audited on a regular basis.	• SCN and Practice Development Nurse (PDN) have met to explore solutions. • PDN will undertake a comprehensive audit of care plans and identify areas of development. • SCN/PDN and Hospital Management Team will meet to review outcome of audit and construct an improvement plan. • Monthly (routine audit) of care plans will be undertaken by Charge Nurses.	3 months	Audits ongoing but staffing consistency a major issue due to high levels of unpredicted absence. PDN to undertake audit as marker. Standards of Ward Management Core Audit schedule has

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Date of Visit	Local Visit	Local Visit Recommendation	Action Plan Response to Recommendation	Timescale	Update
			• Nurse Line Management Supervision will focus on the need for person centred care plans.		been reintroduced which will give wider assurance.
05/05/2021	Timbury Ward, Gartnavel Royal Hospital	3. Managers should ensure that where patients are subject to guardianship, or have a power of attorney in place this should be clearly recorded in their file along with copies of the powers and contact details of the proxy decision maker.	• Review of this issue detailed that it was not a widespread problem and related to a problem obtaining information/paperwork from the patient's Guardian. • SCN will create an admission/discharge checklist to capture and audit this detail.	3 months	There is a system in place to try and capture this however the issue often relates to the Guardian not providing paperwork. The MWC recommendation fails to recognise this.
05/05/2021	Timbury Ward, Gartnavel Royal Hospital	4. Management should update the briefing note on time out and pass, based on current government guidance. Decisions in relation to the management of time outwith the ward should be based on individual risk	This point is disputed. Managers are of the view that the guidance on time out and pass is and always has been in line with Scottish Government.	N/A	See action plan response.

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		assessments and the current guidance and should be kept under review.			
05/05/2021	Timbury Ward, Gartnavel Royal Hospital	5. As restrictions lift, managers should ensure that activity provision is prioritised so patients have access to a range of therapeutic and social activities on a daily basis, to meet needs and preferences. This should include progressing the provision of a dedicated activities co-ordinator post to facilitate this.	• This is out with the control of Hospital Management Team (HMT) and indeed the Head of Service and has been passed on to the appropriate management tier for consideration as it's an area of need HMT have been raising for some time. • The Assistant Chief Nurse is currently reviewing staffing profiles for all clinical areas. • To compensate somewhat our Occupational Therapy department offer the following (not exhaustive): – ADL (activities of daily living) skills practice and development – 1-1 baking sessions – Anxiety management in dealing with everyday activities – Reintegration to managing activities of daily living (AoDL) at home via home visits – Management of household activity sessions – Ward based social and cognitive activity sessions including gardening, recreational activities and Recreational Therapy. In addition to this our Volunteer Coordinator drives a host of complimentary activities including music recitals in the garden and many other activities.	3 months	The Assistant Chief Nurse has submitted costed proposals for consideration. These proposals include a funded activity coordinator model. OT provision continues as stated.

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05/05/2021	Timbury Ward, Gartnavel Royal Hospital	6. Management should address the issue of poor Wi-Fi and TV signal in the ward, and address the problems with the stiff flush system in the toilets.	Flushers • Senior Charge Nurse advised to proactively raise these issues with Hospital Management Team via the many forums open to them to do. • Hospital Management Team have asked the PFI provider of Facility Management to have all 22 rooms in the ward with flush buttons checked for operation with a member of staff and report back. • It is proposed to have flush buttons replaced with wave on/wave off flushers as part of lifecycle work (over the coming years). Wi-Fi • Ward survey will be carried out by IT to identify if boosters can be fitted • IT will produce an options appraisal for HMT/PFI to consider All of the above may be impacted by building regulations and site position.	3 months	Operations Coordinator is progressing work with IT to improve Wi-Fi in the ward.
13/05/2021	Ward 2, Leverndale	1. Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all	All patients DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions will be reviewed at MDTs. Documentation will be checked /audited as part of weekly checks to ensure that documentation is filed appropriately and in date. Line management supervision will address staff awareness and document same.	In place 30/09/2021 14/10/2021	Discussed as routine at MDT meetings and updated.

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		staff members are aware of the DNACPR status of every patient on the ward.			
13/05/2021	Ward 2, Leverndale	2. The service should again review the arrangements for accessing the therapeutic kitchen to ensure maximum benefit of this resource for the patients.	Liaise with Occupational Therapy to establish access /keys. Agree joint plan Standard Operating Procedure regarding maintaining /cleaning /storage etc. Identify staff to complete LearnPro food hygiene updates. Populate list of staff who have skills competencies to use.	30/09/2021 30/09/2021 30/09/2021 30/09/2021	SCN ensuring staff complete safe food hygiene training to support patients within ward to utilise therapeutic kitchen.
13/05/2021	Ward 2, Leverndale	3. Managers should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.	All patients T2 and T3s will be reviewed at multi-disciplinary teams. Documentation will be checked /audited as part of weekly checks to ensure that documentation is filed appropriately and in date. Line management supervision will address staff awareness and document same.	In place 30/0920/21 14/10/2021	Reviewed during MDT meetings, audit process in place to ensure continued compliance.

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13/05/2021	Ward 2, Leverndale	4. Managers should plan to provide single room accommodation to ensure maximum benefit to patients.	Redesign of mental health services and provision of single room accommodation will continually be considered.	Ongoing	Ongoing
18/05/2021	Clyde House, Gartnavel Royal Hospital	1. Managers should undertake a review of OT provision in Clyde House and ensure optimal access to specialist OT lead assessments and activities for patients on this ward.	1. Occupational Therapy (OT) provision was increased since the end of March 2021. Assessments and interventions have been increased since this period. 2. Formal review of Occupational Therapy assessments, interventions and therapeutic activity provision by Lead OT to be undertaken.	3 months (End of January 2022)	OT provision and supervision is consistent with AIMS Standards (Accreditation of Inpatient Mental Health Services). The drop off in provision related to absence and difficulties backfilling this absence despite using all means.
18/05/2021	Clyde House, Gartnavel Royal Hospital	2. Managers must 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	Since the MWC Visit the ward have updated how they monitor (fortnightly): • High Dose antipsychotic use • T2/T3's • Adults with Incapacity paperwork • These findings are presented fortnightly at MDT reviews with immediate action or redress sought. • Organisationally there is a wider audit being undertaken by a Professional Nurse Lead to look	3 Months	Monitoring continues. Await wider organisational work to be undertaken.

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		medication charts, so staff are clear under what authority they are administering medication.	at current good practice and harmonisation of processes across the wider mental health inpatient estate.		
18/05/2021	Clyde House, Gartnavel Royal Hospital	3. Managers should ensure specified persons procedures are implemented for patients where this is required to authorise room searches or other restrictions and all staff are clear on these processes and legislation.	• All nursing staff to include in their PDP (personal development plan) a review of Greater Glasgow and Clyde Specified Person Policy and guidance which links to audit of its use and increased understanding of the range of interventions covered. • The Specified Person Procedure was discussed at the MHS Clinical Governance Group. As such, the group discussed and agreed that they will use this learning to produce a 7 minute briefing to share learning across the system about the procedure. This will be the first 7 minute briefing we have developed.	3 Months 3 Months	Included in staff PDP's and await 7 Minute Briefing to be developed.
18/05/2021	Clyde House, Gartnavel Royal Hospital	4. Managers should ensure that the ward environment is welcoming, fit for purpose and provide the Commission with an update on the programme for refurbishment, including timeframes.	Current works planned (with funding in place): • Flooring replacement • Air Conditioning in kitchen areas	6 months	Operations Coordinator progressing work with Operational Estates though struggling to get schedule of works. If delays persist will escalate to Head of Service.

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18/05/2021	Clyde House, Gartnavel Royal Hospital	5. Managers should plan to provide single room accommodation to ensure maximum benefit to patients.	Plans were submitted and costed several years ago for an extension and upgrade to current accommodation which would make Clyde single ensuite accommodation as part of a total refurbishment therefore the plans are in place for this to occur pending appropriate capital funding being in place to achieve this. The Assistant Chief Officer for Adult Services and the Chief Officer, Finance and Resources plan to visit all Mental Health Inpatient sites to list capital requirements and these in turn will be escalated to the Board capital meeting were decisions of this magnitude are taken.	Escalation will take place immediately.	Escalated to Assistant Chief Officer and await developments.
18/05/2021	Tate Ward, Gartnavel Royal Hospital	1. Managers should at the earliest opportunity review and regularly audit the current care plans to ensure that they reflect the ongoing care and treatment being provided.	• Professional Development Nurse (PDN) has completed care plan audit. Senior Charge Nurse (SCN) and PDN have discussed findings and SCN has implemented changes. • SCN has completed further care plan audits and will continue to do this fortnightly with assistance from Charge Nurse and team leaders. • SCN, PDN and hospital management have met to discuss development needs. • More in depth assessments have been implemented which are reviewed on a weekly basis by named nurses.	4 weeks	Audits undertaken as described and reviewed at regular business meetings. Standards of Ward Management Core Audit schedule has been reintroduced which will give wider assurance.

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18/05/2021	Tate Ward, Gartnavel Royal Hospital	2. Managers should ensure the daily record of contact between nursing staff and patients is meaningful, and includes both a subjective and objective account of the patient's presentation.	• SCN has met with named and associate nurses to discuss this and patient contact notes have improved. • Nurse groups have been identified and have team leaders allocated to review their team notes. Consultant Psychiatrists have been involved in the discussion with regards to more meaningful conversations. • Nurse Line Management (NLM) will identify areas for development and specific issues with nursing notes.	4 weeks	Audits undertaken as described and reviewed at regular business meetings. Standards of Ward Management Core Audit schedule has been reintroduced which will give wider assurance.
18/05/2021	Tate Ward, Gartnavel Royal Hospital	3. Managers should ensure regular audits of progress notes to ensure consistency of record keeping and assist with reviews.	• SCN and Charge Nurse have implemented regular local record keeping audits. • NLM will also assist in highlighting any inconsistencies within the documentation.	2 weeks	Audits undertaken as described and reviewed at regular business meetings. Standards of Ward Management Core Audit schedule has been reintroduced which will give wider assurance.
18/05/2021	Tate Ward, Gartnavel Royal Hospital	4. Managers should ensure a structured activity timetable with activities is available for all patients. Patients who have	• Senior Nurse (SN) has been identified to devise timetable for ward based activities. • 'Isolation packs' have been issued to all new admissions. SN has been identified to audit this.	8 weeks	As described in action plan. The Assistant Chief Nurse has submitted costed proposals for

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		restrictions place upon them and therefore unable to attend the Hub should be provided with activities based upon their areas of interest or need.	• A dedicated activity coordinator post had been discussed, however, the staff member who had been identified is on maternity leave and will explore this on her return. • We have implemented activity care plans for individuals. • As restrictions ease, we are able to offer a wider range of activities for our patient group. • The Assistant Chief Nurse is reviewing staffing profiles for clinical areas. • Our Occupational Therapy department offer: 1:1 sessions with patients several times per week, these sessions include: board games, walks, cooking, lunch group, gardening; and the physiotherapist facilitates gym sessions for interested patients. • Our Volunteer coordinator has facilitated 'garden gigs' for inpatients to enjoy. • We have been offered a grant which will contribute to a garden project - our patient group will be involved in this. • With the help from Volunteer, we have made a bid for a projector and screen for 'movie nights' this is something our patients have requested.		consideration, which will include funded activity planning model. Until this is achieved the ward and Hospital Management Team are at the mercy of unplanned absence and sustained, high levels of clinical acuity.

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08/06/2021	Oak Ward, Inverclyde Hospital	1. Managers should review their audit processes to improve the quality of recovery focussed care plans to reflect the holistic care needs of each patient, and identify clear interventions and care goals.	The Mental Welfare Commission's Good Practice Guide on Care Plans has been shared with all staff members and will be used when reviewing/auditing care plans during Nurse Line Management Supervision, to ensure that care plans remain person centred and recovery focussed and reflect the level of interventions being provided for/required by patients.	Implemented immediately and will form part of ongoing monitoring process.	Implemented immediately and will form part of ongoing monitoring process.
08/06/2021	Oak Ward, Inverclyde Hospital	2. Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.	The patient's Responsible Medical Officer was informed of the issue with regard to T3's in relation to two patients and attended to the matter. Reviewing of patients care records will be addressed within Multi-disciplinary Teams/wards rounds, to ensure that the documentation accurately reflects what is being prescribed.	Implemented immediately and will form part of ongoing monitoring process.	Implemented immediately and will form part of ongoing monitoring process.
08/06/2021	Oak Ward, Inverclyde Hospital	3. Managers should commence a system of audit to ensure that, where relevant, copies of welfare guardianship powers and/or powers of attorney certificates are held within the individuals' care files.	Patients appropriate relative / designated Financial Guardian contacted and asked to bring required documentation to the ward. This has now been added to the patients care record. Mental Welfare Commission's checklist shared with all staff members. Audit of care records will be maintained through the process of Line Management Supervision.	Implemented immediately and will form part of ongoing monitoring process.	Implemented immediately and will form part of ongoing monitoring process.

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08/06/2021	Oak Ward, Inverclyde Hospital	4. Managers should ensure that where covert medication is prescribed the covert medication pathway is completed and reviewed in line with our good practice guidance.	Patient's Responsible Medical Officer informed of issue with regard to review date of Covert Medications documentation and has addressed the matter accordingly. The Mental Welfare Commission's Good Practice Guide on Covert Medications and the requirement for regular reviews of associated documentation has been shared with all staff members and the ongoing auditing of documentation will be maintained through the process of Line Management Supervision. An alert will also be added to EMIS electronic care record as a date reminder of when the documentation requires review.	Implemented immediately and will form part of ongoing monitoring process.	Implemented immediately and will form part of ongoing monitoring process.
21/06/2021	Arran Ward, Dykebar Hospital	1. Managers should introduce processes to meaningfully engage with relatives and carers to ensure not only their needs are met but to improve recovery outcomes for patients.	1. Reintroduction of in depth MDTs (Multi-disciplinary Teams) incorporating families. 2. Also offer remote/internet engagement for relatives, if required. New consultant and new ward manager attempting to engage with relatives and carers over phone to improve involvement and dialogue.	26/11/2021 End Jan 2022 Commenced, completed by end March 2022	Complete Ongoing Ongoing

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21/06/2021	Arran Ward, Dykebar Hospital	2. Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.	a) DNACPR audit conducted and being written up. b) Interventions being put forth included: 1) Documentation at each MDT as part of MDT checklist. 2) Notified in planners that form needs taken out with patient. 3) Put up in covered board listing of patients.	Initial audit completed and action plan developed. Interventions being put in place in December and January For re-audit in February.	Complete Ongoing Ongoing
21/06/2021	Arran Ward, Dykebar Hospital	3. Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form, where required, and a system of regularly auditing compliance with this should be put in place.	Annual review and audit of T3 is underway. This is incorporated within an annual cycle of pharmacy-led checks incorporating PRN audit, Haloperidol prescription and high dose monitoring. Add to MDT checklist to ensure T2/T3 checked prior to medication change.	26/11/2021 MDT checklist for implementation in January 2022	Complete Ongoing

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21/06/2021	Arran Ward, Dykebar Hospital	4. Managers should ensure that the patient's file has a clear record of who has responsibility for the patient's finances and that all welfare or financial proxy details are clearly recorded.	Spending plans and notes of AWI meetings are updated on a six monthly basis and paper copies are put in notes. These will now be proactively uploaded onto EMIS under the title 'spending plan' for ease of finding.	26/11/2021	Complete
21/06/2021	Arran Ward, Dykebar Hospital	5. Managers should ensure that advance statements are promoted in the ward and these discussions are clearly documented in the patient's pathway and care plan.	This will be added to MDT checklist to discuss and will also be proactively discussed at discharge planning phase to ensure that patient is able to participate in the advanced statement process to its fullest.	From January 2022	Ongoing
21/06/2021	Arran Ward, Dykebar Hospital	6. Managers should ensure that the whole ward environment is welcoming and fit for purpose and refurbished to such a standard that the environment is unified to look less like two distinct wards.	Patients are encouraged to personalise space on the Arran side of the ward. Art Therapist in place to assist with regards to this. We are also planning raised garden beds in centre quadrangle to facilitate gardening groups and vegetable/ herb growth for patient activity.	Initial work completed. This will be an ongoing action. May 2022	Complete Ongoing

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21/06/2021	Arran Ward, Dykebar Hospital	7. Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.	NHS Greater Glasgow & Clyde are in the process of implementing their Mental Health Strategy. A sub-group of the strategy is based on mental health rehab services. Part of this work is based on bed-modelling, which, amongst other things, will consider improvements to Rehab ward environments across NHS GG&C.	December 2022	Ongoing
22/06/2021	IPCU, Leverndale	1. The Commission will escalate the issue of long patient stays in this IPCU to the hospital's senior managers and senior clinicians; we will also write separately to the NHS GG&C Health Board Chief Executive Officer about our concerns.	Senior clinicians aware of situation; ongoing discussion at bed management meeting regarding patient movement. Discharge Co-ordinator also in contact with forensic bed manager regarding beds booked in that service.	Ongoing	Deputy Medical Director has written an SBAR report and presented this to the board. One patient awaiting Learning Disability placement has been transferred. Assessment ongoing for remaining patients awaiting low secure forensic bed.
22/06/2021	IPCU, Leverndale	2. Managers to address the issue of psychology provision to the IPCU ward.	There is dedicated time from the Clinical Psychology Consultant who has attended Ward 1 MDT meetings and carried out really invaluable and informative formulations for our patients within our care and was at the time of the Mental Welfare Commission visit to this ward area.	Ongoing	Consultant Psychologist continues input within IPCU, working with MDT process to identify

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					patients for psychological support. Trained staff within IPCU supported to attend training on delivering low intensity psychological therapies to patients within IPCU. Trauma informed care, Co-ordinated clinical care for treatment of Borderline Personality disorders.
23/06/2021	Isla Ward, Stobhill	1. Managers should put an audit system in place to ensure that all medication prescribed under the Mental Health Act is properly authorised.	SCN liaised with Responsible Medical Officer (RMO) colleagues to discuss the importance of reviewing T2 and T3 at weekly MDT (Multi-disciplinary Team) reviews to ensure any changes to patient's psychotropic medication is reflected through current T2 and T3. The recommendations were discussed at the ward team meeting and following actions agree: • As part of ward weekly checks, T2 and T3 forms will be checked against patient's prescription	Immediate Effect Immediate Effect	Complete Professional Development Nurse will undertake an audit

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			kardex- ensuring any anomalies are escalated to RMO to be amended/ rewritten, as a matter of urgency • Through weekly MDT reviews, T2 and T3 will be discussed/ reviewed as part of a rolling agenda • Pharmacist now attends ward weekly MDT reviews		before end April 2022 to ascertain if ward improvements have been embedded into practice.
29/06/2021	Ailsa Ward, Stobhill	1. Managers should review all current T3 certificates ensuring medical staff pursue Designated Medical Practitioner (DMP) visits urgently.	Senior Charge Nurse (SCN) discussed the recommendation and requirement to review T3 certificates with Responsible Medical Officer (RMO). Audit carried out by ward Pharmacist and changes made to medication prescriptions to reflect current authorised medications. Requests made for DMP visits which have since taken place.	Immediate	Recommendations carried out and actions completed.
29/06/2021	Ailsa Ward, Stobhill	2. Managers should put an audit system in place to ensure that all medication prescribed under the mental health act is legally authorised.	Audit system now in place to monitor medication prescriptions and administration are in line with current T3 certificates. 1. Nursing staff to check T3 certificates weekly against kardex to ensure that all prescribed medications are authorised by T3 certificates. 2. When ward GP or duty doctors are prescribing medications, ward nursing staff to prompt them to ensure they are checking T3 certificates for authorised medications. 3. T3 monitoring added as a weekly standing agenda item for MDT reviews. RMO to refer to MWC for DMP review if medication changes are thought necessary that are not authorised by current T3 certificates.	Immediate	Recommendations carried out and actions required have been completed.

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			4. Pharmacy colleagues have once again commenced with their weekly attendance at MDT which assist us as a team to ensure we are compliant with T3 and prescribing. They will also carry out regular audits as an added assurance measure.		
29/06/2021	Ailsa Ward, Stobhill	3. Managers should ensure that the rehabilitation service receives dedicated Therapeutic Activity Nurse provision commensurate with that provided to other wards on the hospital site.	Ailsa SCN continues to agree with MWC that the addition of Therapeutic Activity Nurses (TAN) to Ailsa ward would be a vital addition to the MDT. This additional resource would provide much needed social integration, activity and a much greater structured use of time for the patients in Ailsa. It would also provide opportunity for the ward to become much more of community with the patients coming together in similar interests which they enjoy, encouraging each other, spending time together and promoting engagement with each other and with staff.	Ongoing	Recommendation not met. Ailsa ward continues without TAN at present. SCN to continue to recommend and pursue TAN involvement with in Ailsa ward.
29/06/2021	Ailsa Ward, Stobhill	4. Managers should plan to provide single room accommodation to ensure maximum benefit to patients.	SCN not aware of any plans to change 2 x four bedded dormitories into single room accommodations.	Ongoing	To be discussed with Adult In-Patient Services Manager at SCN 1:1.
30/06/2021	Fruin & Katrine, Vale of Leven	1. Managers should review their audit processes to improve the quality of mental health care plans to reflect the holistic	Fruin/Katrine Ward senior nurses will audit care plans monthly and action plan as necessary. This audit will evaluate whether care plans reflect the MWC Person Centred Care Plans Good Practice Guide. This will promote a human rights and person centred approach to care planning,	December 2021	The action has been implemented and the action is an ongoing plan.

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		care needs of each patient, and identify clear interventions and care goals.	that reflects outcomes that are not just specific to medical and nursing care.		
08/07/2021	Ward 37, Royal Alexandria Hospital	1. Managers should ensure that care plans are evaluated and updated to reflect changes to patients' needs and the effectiveness of interventions.	Care plans reviewed and updated with ongoing review by Senior Charge Nurse. Further audit of care plans to be completed by December 1st.	30/09/2021 01/12/2021	Action complete This action is complete and an action plan has been developed.
08/07/2021	Ward 37, Royal Alexandria Hospital	2. Managers should ensure there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and this should be reviewed regularly.	Ward Nursing staff are working in liaison with Clinical Psychologist to ensure Stress and Distress/Newcastle Formulation Care Plans are developed and in place for patients who require these. Further audit of stress and distress care plans to be completed by December 1st.	30/09/2021 01/12/2021	Action ongoing This action is complete and an action plan has been developed.

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08/07/2021	Ward 37, Royal Alexandria Hospital	3. Managers should ensure that "getting to know me" and other life history documentation is fully completed and follows patients when they move to other care settings.	Each patient has an up to date "getting to know me" document and this is filed appropriately within their individual health record for ease of access for staff and also for when patients are transferred, document is with all files.	30/09/2021	Action ongoing
08/07/2021	Ward 37, Royal Alexandria Hospital	4. Managers should ensure that where there is a proxy decision maker, this is recorded and the legal proxy is consulted appropriately.	Legal documentation checked and clarified on admission. Reviewed at each Multidisciplinary Team Meeting and also regular secondary check by Named Nurse during care plan reviews when updating legal status, AWI status or DNACPR status. An audit of this will be included in the further care plan audit scheduled for December 1st 2021	30/09/2021 01/12/2021	Action complete This action is complete and an action plan has been developed.
08/07/2021	Ward 37, Royal Alexandria Hospital	5. Managers should review the visiting arrangements to maximise the number of visits which can be accommodated and ensure that patients are able to receive visits as frequently as possible.	Review fully completed following meeting with MWC and new system implemented by 30/09/2021. New visitor folder allows visitors to book visits either the morning, afternoon or evening. Visits can take place in the Dining room or patient's own single bedroom. Further capacity has been created by utilising the Snoezelen room for visiting during the afternoon and evening. This has greatly increased overall capacity for visitation. There have been no further concerns	30/09/2021	Action complete

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			from relatives regarding issues to visiting family members.		
08/07/2021	Ward 37, Royal Alexandria Hospital	6. Managers should ensure that patients who require support to use technology to maintain contact with family are supported to do this.	Ward 37 can facilitate use of Ipads and mobile/landline phones and assistance should be reflected in their care plans on development of these by the patient's Named Nurse. This will be audited as part of the further care plan audit scheduled for 1st December 2021	30/09/2021 01/12/2021	Action complete This action is complete and an action plan has been developed
08/07/2021	Ward 37, Royal Alexandria Hospital	7. Managers should ensure that advocacy services are available to patients and information about this is displayed within the ward area.	Advocacy information is now displayed on the Family and Carer News and Information Noticeboard on entrance to the ward and also information leaflets available within the ward environment. This display information is reviewed and maintained by the Ward Clerk.	30/09/2021	Action complete
08/07/2021	Ward 37, Royal Alexandria Hospital	8. We recommend that a full environmental audit is commissioned and an action plan is developed to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group. Managers	The King's Fund Environmental Audit was completed by Operations Nurse Manager, RAH facilities staff member and Operations Co-ordinator on 28th September 2021. Many of the issues identified remain as of previous environmental audits and also reflect the concerns highlighted by the MWC and these have been escalated by Service Manager and the Head of Service to Chief Executive Officer again.	30/09/2021 30/09/2021	Action complete Actions complete

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		should highlight our concerns in relation to the environment to the chief executive officer and we will also write directly to express our concerns.	Within NHSGGC there is a current bed modelling process regarding older person's mental health services and all clinical areas are in the process of being reviewed with regards to capacity, need etc. with the possibility of relocation of resources. This is ongoing. No decisions have been made regarding the environment with regard to new builds etc. Action currently in the process of being undertaken or completed. • Delivery of new furniture for the whole ward area – this had been delayed due to COVID-19 restrictions although had been ordered at time of MWC review. • The tired visual environment is in the process of redecoration with more appropriate paint choice, chosen by the nursing staff. Areas appearing brighter and fresh. • Following the redecoration of Ward 37, the Art Therapist, that provides sessions to the Renfrewshire OPMH Wards, will paint murals on some of the walls within the ward. These will depict local landmarks that will be recognisable to the patients. A further environmental audit will be completed by the Operations Nurse Manger by 28 February 2022	December 2022 29/11/2021 29/11/2021 25/03/2022 28/02/2022	Action ongoing Action complete Action complete Action ongoing Action ongoing

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08/07/2021	Ward 37, Royal Alexandria Hospital	9. Managers should undertake a review of the current system for managing both hospital and take home laundry and take necessary actions to ensure a more efficient system.	Review of limited storage space within Ward 37. Plan to restructure rooms to create a room for clean clothing storage and a separate room for take home laundry. This will require shelving and appropriate containers for storage of take home laundry.	25/03/2022	Action ongoing
12/07/2021	Langhill Clinic, Inverclyde	1. Managers should formally review the care and treatment plans of all patients who have been in the IPCU for six months or more.	[redacted] Redacted clinical information.	Dependent on bed availability for transfer.	Ongoing
12/07/2021	Langhill Clinic, Inverclyde	2. Managers should address the difficulties relating to access to psychology services and psychological therapies.	A psychology post was agreed via GGC Psychological Therapies Plan over a year ago, funded by Scottish Government. Unfortunately we failed to recruit to an 8A post (1.0wte) despite numerous attempts. The post has now been reconfigured to an 8B post (0.8wte), covering the acute wards and also provide an interface with Community Response Service (CRS). Interviews take place 11th March 2022. There is a further plan to provide psychology cover to Langhill in	March 2022	Ongoing

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			the event that there are any further recruitment issues.		
12/07/2021	Langhill Clinic, Inverclyde	3. Managers should improve and formalise engagement with carers.	Nursing staff will ensure that they record patients' consent regarding the involvement of their relatives/carers. Staff to ensure that all engagement with relatives/carers is documented in the patient's care record and that the views of relatives/carers are considered and included to help inform the care and treatment being provided to their loved ones.	Ongoing	Ongoing
12/07/2021	Langhill Clinic, Inverclyde	4. Managers and RMOs should: • review all current consent to treatment (T2 and T3) certificates to ensure they are appropriate • ensure T2 consent forms are present where required and that DMP visits are arranged where required for T3 certificates	The patients Responsible Medical Officer was informed of the issue with regard to T2/T3 certificates and immediate action was taken to address the matter. Reminders from Medical Records to Consultants and the nursing team to review patients for lapsing T2/T3. Weekly assurance check for current T2/T3 documentation at MDT/ward round. MDT to review the requirement for T2/T3 or acknowledge current T2/T3 in place.	Implemented immediately and will form part of ongoing monitoring process.	Implemented immediately and will form part of ongoing monitoring process.
12/07/2021	Langhill Clinic, Inverclyde	5. Managers should put an audit system in place to ensure that consent to	Reviewing of patients care records will be addressed within MDTs/wards rounds, to ensure that the correct documentation/certificates are in place.	Implemented immediately and will form part of ongoing	Implemented immediately and will form part of ongoing

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		treatment certificates are in place where required.		monitoring process.	monitoring process.
12/07/2021	Langhill Clinic, Inverclyde	6. Managers should ensure that patients (particularly in the IPCU) have activity addressed in their care plans; these plans require to be person centred reflecting the individual's preferences and care needs.	1) Ensure adequate staffing and resource for Occupational Therapy provision. 2) Occupational Therapist to utilise Standardised Documentation including Initial Assessment, person-centred plan and functional assessments where applicable. 3) Occupational Therapists to provide person-centred therapeutic activities including creativity, utilising outside space or sports equipment, using digital tools to increase concentration and motivation. 4) The Mental Welfare Commission's Good Practice Guide on Care Plans has been shared with all staff members and will be used when reviewing/auditing care plans during Nurse Line Management Supervision, to ensure that care plans remain person centred and recovery focussed and reflect the level of interventions being provided for/required by patients.	Ongoing	Ongoing
12/07/2021	Langhill Clinic, Inverclyde	7. Managers should address the temperature regulation within the clinic to achieve effective ventilation for the comfort,	The NHS GGC Estates team have submitted an options paper and considering how the installation can take place, avoiding disruption to patient care whilst the environmental works are undertaken. There is no timescale for completion of the works, as yet but it is hoped that this will be within the coming year.	Focus continues on progression of works.	Ongoing

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		health and safety of staff and patients.			
24/08/2021	Wards 4 A & B, Larkfield Unit, Inverclyde	1. Managers should audit to ensure that Getting To Know Me documentation is fully completed and life history information is recorded and follows the patient when they move to a further care placement.	Medical and nursing staff collect brief history during initial assessment. Occupational Therapy (OT) staff to support in life history work and collating of information from family. Getting to me know me paperwork to be given to NOK/ family to complete on admission, with assistance/guidance from nursing/OT staff where required. Quality assurance audit of patients care records will be carried out during a programme of regularly scheduled Nurse Line Management supervision sessions.	Ongoing	Actions ongoing
24/08/2021	Wards 4 A & B, Larkfield Unit, Inverclyde	2. Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.	All care plans, will be audited for quality assurance to confirm the content is person-centred and reflects the current care needs of the patient. Stress and distress training sessions/refreshers have commenced for staff, with ongoing input from psychology to compile and review stress and distress formulations for identified patients. Quality assurance of care records will be carried out during a programme of regularly scheduled Nurse Line Management supervision. Senior Charge Nurse (SCN) to re-circulate the MWC Person Centred Care Plans good practice guidance. Core audits for record keeping provide further quality assurance via quarterly audits.	Ongoing Ongoing Completed 10/09/21	Action ongoing Action ongoing Action complete

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24/08/2021	Wards 4 A & B, Larkfield Unit, Inverclyde	3. Managers should review their audit processes to improve the quality of mental health care plans to reflect the holistic care needs of each patient, and identify current interventions and care goals.	SCN to re-circulate the MWC Person Centred Care Plans good practice guidance. All care plans, will be quality assured to ensure the content is person-centred and reflects the current care needs of the patient. Quality assurance of care will be carried out during a programme of regularly scheduled Nurse Line Management supervision. Commencement of core audits for record keeping provide further quality assurance via quarterly audits.	Completed 10/09/2021	Actions complete
24/08/2021	Wards 4 A & B, Larkfield Unit, Inverclyde	4. Managers should audit to ensure that where an individual lacks capacity there is a valid s47 certificate in place to authorise treatment.	Medical staff to ensure capacity assessed on admission to ward and reviewed as part of the weekly MDT review, with S47 certificate being granted and completed fully if required. Record review date as an alert on EMIS. Named nurse to ensure all paperwork is checked when reviewing legal aspects of care, care plan and record within Multi-disciplinary Team Meeting (MDT) preparation template. Registered nursing staff to review Section 47 certificate for accuracy of detail and completion in full. Core audits for record keeping completed by SCN/Charge Nurse to provide audit process and quality assurance of certificates.	Ongoing	Action ongoing

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24/08/2021	Wards 4 A & B, Larkfield Unit, Inverclyde	5. Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted in relation to s47 certificate; the manager must ensure that this process and outcome is clearly recorded.	Medical staff to ensure consultation with proxy decision maker when granting Section 47 of the Adults with Incapacity Certificate (AWI). On completion of MDT preparation template, registered nursing staff to review Section 47 certificate for accuracy of detail and completion in full and escalate any inaccuracies/omissions to Consultant, Medical Staff and Senior Charge Nurse. Nurse in Charge and named nurse to review all completed individual patient admission paperwork including section 47 certificate to ensure proxy decision maker or relative is recorded on Section 47 certificates.	Ongoing	Action ongoing
24/08/2021	Wards 4 A & B, Larkfield Unit, Inverclyde	6. Managers should ensure that patients have activity care plans which are person-centred, reflecting the individual's preferences (alongside activities specific to their care needs).	SCN circulated guidance for staff to complete activity care plans for individual patients, taking in to account occupational therapy activity plans. Support from Occupational Therapist to create person centred robust activity care plan for patients. Patient Activity Coordinator (PAC) to provide support to patients to maintain social and recreational activities, hobbies, pastimes and interests.	Completed 10/09/21 Ongoing Ongoing	Action complete Action ongoing Action ongoing

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31/08/2021	Ward 39, Royal Alexandria Hospital	1. Managers should ensure that where it is recorded that a patient is subject to provisions of the AWI Act, the specific provision of the Act is identified, i.e. s.47, POA, or Guardianship.	Update section of Patient status at a glance board to reflect AWI. Ensure this specifies Section 47, section 37, POA, and Guardianship as appropriate. Review of care plans to ensure this is reflected via next round of nurse line management.	29/10/2021 29/10/2021	Complete Complete
31/08/2021	Ward 39, Royal Alexandria Hospital	2. Managers should ensure that activity care plans are developed reflecting the individual's preferences and care needs, and that activity participation is recorded and evaluated.	Support the introduction of an initial assessment care plan for identifying meaningful activity. Work collaboratively with OT to develop patient personal activity planner. Ensure short term and long term goal setting evident in care plan reviews.	26/11/2021 26/11/2021 26/11/2021	Complete Complete Complete
07/10/2021	Cuthbertson Ward, Gartnavel Royal Hospital	1. Managers should ensure that MDT meeting notes record who was present and contain details of current issues and presentation, decisions taken, actions required and future plans in	• Communication sent round all members of the Multi-disciplinary Team (MDT) detailing points made within recommendation. • Amended MDT Checklist is being drafted which will assist process and recording of outcomes. • Designated member of MDT identified to scribe at MDT meetings which is complimented by collective proof reading at end.	1 month	Actions in place.

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		relation to the care goals, treatment and discharge of patients, and this should be audited to ensure consistent quality of record keeping.	• MDT to agree audit frequency of all the actions detailed above.		
07/10/2021	Cuthbertson Ward, Gartnavel Royal Hospital	2. Managers should put an audit system in place to ensure that all medication prescribed for patients who are subject to compulsion under the mental health act is properly authorised.	• Signed Weekly Checklist which details all work to be undertaken: this is monitored by the Senior Charge Nurse. • T2/3 Audit will be completed set to the frequency as set by current NHS GG&C Policy and Guidance. • Findings of the aforementioned audit will be presented at MDT Review. • MDT Checklist includes both T2/3 and Section 47 Paperwork thus ensuring it sits and is reviewed in the MDT domain.	1 month	Actions in place.
03/11/2021	Banff Ward. Leverndale Hospital	1. Managers should audit care plans on a regular basis to ensure the interventions are person centred, care plans are updated following evaluations to reflect any changes in the individuals care needs, and legal	Care planning is evidenced to be taking place with this report and Combined Care Assurance Audit Tool (CCAAT) audit reflective of this. Time constraints and current pressures may be the reason for changes not being captured and Senior Charge Nurse will explore options to free up time for trained staff to evaluate care plans as part of daily ward routines. Senior Charge Nurse and PDN will look at how best to capture qualitative information to ensure	June 2022 June 2022	Actions ongoing

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		status and that patient participation is recorded.	monthly audits of care plans reflect changes in individuals outlined in MWC recommendations.		
03/11/2021	Banff Ward. Leverndale Hospital	2. Managers should put an audit system in place to ensure that all medication prescribed for patients who are subject to compulsion under the Mental Health Act is properly authorised.	Audit currently in place but appears to be human error led to this not being picked up during audit. CCAAT audit 30 September 2021 by PDN did not show any errors and results of this audit was 100% in the 5 records sampled. To ensure continued adherence to this, audits will be minimum monthly and use CCAAT to guide this process. PDN will re-audit March 2022 using CCAAT Pharmacy have annual Routine Audit Schedule planned and this will be a further safeguard to ensure compliance with recommendations of MWC.	June 2022 March 2022 December 2022	Actions ongoing
03/11/2021	Banff Ward. Leverndale Hospital	3. Managers should put a system in place to ensure that where there is a proxy decision maker this is recorded and a copy of the powers are held in the patient's file.	Admission checklist includes "Check if patient has Advanced Statement/POA/Guardianship in place and request copy of documentation". Senior Charge Nurse will implement procedure to revisit this for all patients within 14 days of admission to ensure this has been fully addressed or revisited following admission and will be included in care plan audit questions to ensure compliance. Service manager to have discussion city wide regarding standardising recording of POA on EMIS.	March 2022	Action ongoing

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