



Mental Welfare Commission for Scotland

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

Date of visit: 30 July 2019

Where we visited

Cuthbertson ward has 20 beds and provides assessment and treatment for individuals with a diagnosis of dementia. The ward is situated on the first floor of a purpose-built hospital and provides individual rooms with en-suite facilities. The ward is bright and spacious with a number of sitting areas, a separate dining room, and activity space. The ward has a pleasant enclosed garden space, directly accessible from the dining room. We last visited this service on 6 November 2018 and made recommendations relating to care planning and consultation with families/proxy decision makers.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and also look at activity provision and life histories. This is because of the importance of these aspects of care for individuals with dementia.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and one relative.

We spoke with the charge nurse, the patient activity co-ordinator, and other members of the nursing team.

Commission visitors

Mary Hattie, Nursing Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The ward has input from four consultant psychiatrists and junior medical staff, and regular input from two full-time occupational therapists and a technician, who work across this ward and the functional assessment ward next door. There is regular input from a pharmacist, who attends the multidisciplinary team (MDT) meetings and provides advice around medication reviews. Social work and other allied health professionals are available on a referral basis and provide a responsive service.

There is no regular access to psychology input for individuals identified with stress and distress; however a number of staff have been trained in the use of the Newcastle model. This is a psychosocial model that provides a framework and process in which to understand behaviour that challenges in terms of needs which are unmet, and suggests a structure in which to develop effective interventions that meet those needs and reduce or manage the behaviours.

MDT meetings are held weekly. We found that the MDT meeting notes were of good quality providing information on progress to date, decisions made and evidence of carer/relative/proxy decision maker involvement.

Within the files we reviewed, we found detailed initial assessments and risk assessments which were reviewed on a regular basis. Physical health needs were being addressed and care plans were in place for these.

We looked at the files of several patients where there was evidence in the chronological notes that they were expressing stress and distress. For some patients there was no care plan to address this; for others the care plan which was in place was superficial using stock phrases such as 'de-escalate'; providing no information about triggers or interventions which were effective for the individual.

Some of the files we reviewed contained a completed Getting to Know Me. This is a document which records a person's needs, likes and dislikes, personal preferences, and background aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. However, there was little evidence of fuller life story information being recorded. As most patients will move on to further care placements, it is important that this information is recorded and goes with them through their care journey

Ward staff were visible in the ward and engaging with patients throughout our visit. Staff clearly know their patients well and there was a warm, welcoming and calm atmosphere within the ward.

Recommendation 1

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 this should be regularly reviewed.

Recommendation 2

Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement. The Commission has published a joint report on the quality of care for people with dementia living in care homes in Scotland which can be found here: [Remember I'm still me.](#)

Use of mental health and incapacity legislation

Where patients were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), legislation copies of detention paperwork were on file and the Mental Health Act recording sheets provided information on when detention commenced and was due to be reviewed.

Part 16 (sections 235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients. Where they were required, we found T3 certificates authorising all prescribed treatment.

In relation to the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), where the patient had granted a Power of Attorney (PoA), or had a guardianship in place, we found copies of the powers on file with contact details for the proxy.

Section 47 of the AWI Act authorises medical treatment for people who are unable to give or refuse consent. Under section 47, a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity.

We found s47 certificates in place for the patients whose files we reviewed and where there was a proxy decision maker they had been consulted.

Where individuals were receiving covert medication there was a covert medication pathway in place and information from pharmacy on how medication should be dispensed.

Rights and restrictions

The ward door is secured and access is controlled by nursing staff, for reasons of patient safety. There is a locked door policy and information is available to visitors on how to leave the ward.

The Commission has developed [Rights in Mind](#). This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:

<https://www.mwcscot.org.uk/law-and-rights/rights-mind>

Activity and occupation

We were pleased to see that ward has an activity co-ordinator, who provides a range of therapeutic and recreational activities, in group format and on an individual basis both within and out with the ward. We witnessed various small group activities happening throughout the visit, involving patients and nursing staff along with the activities coordinator. We saw the structured weekly activity programme, which provides a wide variety of activities including a number provided by community organisations, such as a visiting therapist, and the Common

Wheel, who provide a weekly musical session which carers and relatives are also encouraged to participate in if they wish.

The activity co-ordinator is trained in cognitive stimulation and spoke with us about the work she is developing, including individual reminiscence sessions using sensory stimulation.

We heard that funding has been secured for an interactive activity table which will be a very useful additional resource. This table offers patients the ability to interact with projected pictures and sounds which react to their touch and can be used in a variety of ways, with individuals and groups. We look forward to seeing this in use on our next visit.

The physical environment

The ward is bright, spacious and in good decorative order, there are a number of quiet spaces as well as the larger sitting areas. The artwork on the windows with pictures from old Glasgow add interest to the environment.

The garden is well designed with plenty of seating and is easily accessible, this was being well used during our visit.

Summary of recommendations

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Recommendation 2

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Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

MIKE DIAMOND
Executive Director (Social Work)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons Inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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