Mental Welfare Commission for Scotland

Report on announced visit to: Claythorn House, Gartnavel Hospital, 1055 Western Road, Glasgow G12 0XH

Date of visit: 17 December 2019

Where we visited

Claythorn House is a 12-bedded acute assessment and treatment unit within the Gartnavel Royal Hospital site. It is staffed by NHS nurses with sessional time provided by two consultant psychiatrists, psychology, occupational therapy, speech and language therapy, and physiotherapy. There is one activity nurse providing input. The unit has access to 24-hour on-site psychiatry cover through the duty system at Gartnavel Royal Hospital. There is sessional GP input and GP urgent medical cover provided during normal working hours. Urgent medical and psychiatric cover out with normal working hours is provided by the duty doctor at Gartnavel Royal Hospital.

We last visited this service on 19 April 2019 and made recommendations about auditing case files, ensuring copies of guardianship powers are included in files, and monitoring discharge planning for patients whose discharge had been significantly delayed.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations, particularly in relation to delayed discharges. This is because the *Strategy for the Future NHS GGC 2015* made a recommendation that the NHS should not be a long term provider, and that people should be supported to live independent lives outwith hospital settings where possible. This aspiration was reinforced when guidance on hospital based complex clinical care was issued in May 2015, replacing guidance on NHS continuing healthcare contained in CEL26 (2008). The MWC also published its report *No Through Road* in 2016 and more recently the Scottish Government has published the *Coming Home* report, each highlighting the requirement to improve the lengths of time people wait to be discharged form hospital. NHS Greater Glasgow and Clyde strategic direction is in keeping with these reports and national policy for people with learning disabilities.

We were pleased to hear that a particularly complex delayed discharge had been effected which has required extensive planning across both statutory and third sector agencies and has been a good example of a complex process which retained a person-centred focus and has resulted in a positive outcome for the patient.

In addition, plans are being finalised for another patient to move to a community resource early next year.

On the day of our visit, there were 10 patients on the ward, one of whom was in a transition process from another service.

Who we met with

We spoke with the service manager and the senior charge nurse (SCN), and met a range of other staff during the visit.

We reviewed the care and treatment of eight patients and met with three relatives.

Commission visitors

Yvonne Bennett, Social Work Officer
Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

During the visit we met with three family members who were highly complimentary about the service provided within the ward. They advised that they found staff to be approachable and welcoming of their involvement in their family member's care, and that the care provided to them overall was of a high standard.

The service currently is in transition from paper records to electronic recording and as a result information is located across both platforms which can be confusing. In addition, a daily working file is in operation to record routine daily checks and we felt that this additional record further complicates accessing relevant information. We are aware that in line with other units across the service, this is an interim position but this transition should be managed quickly to minimise duplication and potential errors.

We reviewed the care plans and noted the complexity of care which is being provided within the ward. The care plans are very detailed and reflect nursing interventions, but we feel they could reflect more of a person-centred perspective and where possible involve the patient in this process. We saw in some case records accessible care plans which we felt were a good example of how this could be done and we would like to see this practice rolled out routinely across the service.

Care plan reviews, although noted timeously, were basic and often reflected "no change". Given the complexity of the care provided, and the primary function of the ward being assessment and treatment, we would expect these reviews to be more robust, identifying progress and targeting nursing intervention to continue this progress.

Within the records of the multidisciplinary team (MDT) meetings, there was evidence of the involvement of the full range of disciplines as well as families and carers where appropriate. We would like to see a review of observation levels recorded routinely within these meetings to ensure that patients were receiving the correct level of observation in line with their assessed and reviewed needs.

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

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 1:

Managers should audit the process for reviewing care plans which reflect progress towards goals, acknowledge achievements and respond to changes.

Use of mental health and incapacity legislation

There were five patients on the ward on the day of our visit who were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All the relevant legal paperwork was up to date and contained within patient files.

In addition, a number of the patients were also subject to welfare guardianship under Adults with Incapacity (Scotland) Act 2000 and there were copies of these orders, detailing the powers they contained within patient files.

Certificates authorising treatment (T2/T3/T4) were in place, authorising the prescription and administration of routine medication. and in response to urgent need for treatment.

Rights and restrictions

Claythorn House operates a locked door policy commensurate with the levels of vulnerability of the patient group. There are individual detailed risk assessments in place for patients which detail arrangements for time off the ward and support required to facilitate this safely.

On the day of our visit there were four patients who were on enhanced levels of observation, and we heard that the level of enhanced observations within the ward was generally high. We noted that for some of the patients who were subject to enhanced observation, this had been in place for prolonged periods. Improving Observation Practice guidance recommends that this high level of intervention should be reviewed after 24 hours to assess its effectiveness. Within the patient records there was limited evidence of these review processes being conducted, although we heard from staff that enhanced observations were reviewed regularly.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. On the day of our visit, there were three patients who were subject to additional restriction under these sections. Paperwork in relation to this additional restriction was not fully completed and staff agreed to follow this up with relevant medical staff.

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/rights-in-mind/

Recommendation 2:

Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

Activity and occupation

The ward has a dedicated activity nurse post and this post is effective in ensuring that patients have individual activity planners which covered social, recreational, and rehabilitation activities.

These activities are delivered both within the ward and in the community, supported by staff where appropriate. These include access to art therapy, walking groups, daily cooking/baking groups, film nights, and various seasonal activities.

In addition, we saw a number of patients who were supported by private providers as part of a transition preparation working towards discharge.

The physical environment

Claythorn House is a self-contained unit within the grounds of Gartnavel Hospital. It offers bright, well-maintained accommodation with single bedrooms. The design of the building has resulted in six large bedrooms with en-suite toilet and shower facilities, and six smaller bedrooms with en-suite toilet facilities but patients are required to access one of three showers available within the corridor. This imbalance does cause some issues among patients, although rooms are allocated on a needs led basis initially, then based on length of admission.

There are a number of communal lounge areas for use depending on patient choice and a small garden area.

Summary of recommendations

1. Managers should audit the process for reviewing care plans which reflect progress towards goals, acknowledge achievements and respond to changes.

2. Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

Good practice

As described earlier, the ward has recently been instrumental in supporting a complex discharge which required intensive training for new providers and this was facilitated within the ward, using a range of hands on training and technology to ensure an effective and safe discharge. This has been a learning experience for all concerned and has required staff to work collaboratively and supportively to make this happen. This has been an example of good practice and has offered a template for future planning for complex discharges.

During the visit we heard that specialist learning disability inpatient services has commenced a redesign of assessment and treatment services and are working with all partners to determine the most effective service provision.

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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