Mental Welfare Commission for Scotland

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

Date of visit: 18 May 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Routemap (May 2020). There have however been periods during the pandemic where we have been able to conduct our face-to-face visits. This local visit was able to be carried out face to face and we used a combination of telephone interviews and in person interviews on site at Clyde House.

Clyde House is an 18-bedded high dependency, mixed sex intensive rehabilitation ward providing care and treatment for adults with severe and enduring mental health problems. The rehabilitation service in Gartnavel Royal Hospital consists of two wards, Clyde House and Kelvin House. The function and configuration of these two wards was revised in 2017 and the rehabilitation service as a whole is currently under review as part of the City Wide Rehabilitation Review Group. At present the bed configuration in Clyde is 14 beds for patients requiring a slower paced intensive rehabilitation and four hospital based complex care beds for patients who may have more complex needs and for a variety of reasons, present with behaviours which can be challenging.

We last conducted a local visit to this service on 7 March 2017, but also visited in 2018 as part of our themed visit to rehabilitation wards in Scotland. Following our 2017 visit we made recommendations in relation to high dose antipsychotic therapy records, the completion of life histories for each patient, consent to treatment authorisation, and the availability of a washing machine.

We were keen to visit Clyde House at Gartnavel Royal Hospital as it had been some time since our last local visit and we had received some correspondence from patients and relatives.

There is a weekly referral meeting where consideration is given to suitability for either ward. The patients in Clyde Ward generally need a longer period of rehabilitation than those in Kelvin Ward and the length of rehabilitation is likely to be in excess of two years due to the complexity of the patients' mental health and / or behavior needs. Patients' motivation and engagement can be poor due to the chronic nature of their illness.

On the day of this visit we wanted to follow up on the previous recommendations and also find out how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and on the mental health of patients. We also wanted to give patients an opportunity to raise any issues with us and to ensure the care and treatment and the facilities are meeting patients' needs.

Who we met with

We met directly with four patients and reviewed the care and treatment of seven. We spoke with the senior charge nurse, a charge nurse a consultant psychiatrist and two staff nurses.

Commission visitors

Lesley Paterson, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

We heard from staff and patients that care has continued very much as normal throughout the Covid-19 pandemic with patients continuing to have good access to their psychiatrist and input from the wider multidisciplinary team and advocacy services. We were pleased to hear that although subject to some ongoing restrictions, most patients have generally coped well with the experience of the ongoing pandemic and understand the need for the restrictions and change in practices.

Care, treatment, support and participation

The patients we spoke to were generally very positive about the care and treatment provided by the clinical team. There is a diverse group of patients in the ward. Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their ability to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. We did however see evidence of considerable efforts by nursing, occupational therapy (OT) and psychology staff to encourage engagement in both their treatment and activities.

Clyde House is currently served by one part time locum consultant psychiatrist, a part time clinical psychologist and occupational therapy staff. There is a fortnightly multidisciplinary team (MDT) meeting. Referrals are made to physiotherapy, dietetics, podiatry or speech and language therapy if indicated and patients are supported to attend all national screening initiatives as required. There is a visiting GP service and all annual health checks are carried out along with any other required monitoring including bloods for Clozapine therapy, high dose antipsychotic monitoring, and diabetic monitoring. Although pharmacy staff do not currently routinely attend the MDT meetings, they are available for consultation, completion of medication reviews and will spend time with patients discussing their medication if this is required.

We heard there has been a lack of consistent psychiatry provision, (seven psychiatrists over the past six years), which has been challenging for staff and patients. The current locum psychiatrist will be leaving their post soon. We would hope managers are alert to the potential detrimental impact inconsistent medical provision can have on a clinical area, patient care and MDT working and factor this into any future planning.

Patients are invited to attend the MDT meeting but some choose not to and instead will liaise with their consultant psychiatrist and nursing staff prior to the meeting to ensure their views are conveyed and then receive post meeting feedback afterwards. When appropriate, relatives are invited to attend MDT meetings via video conferencing. Some patients in Clyde House are managed on the Care Programme Approach (CPA) and some attend their meetings. Regular community meetings take place and these allow for patients to discuss any ward based issues, concerns or views they may have. The patients report that these meetings are useful, supportive and they feel their views are listened to. MDT meetings were clearly recorded and in most cases it was clear to see who attended and what the meeting outcomes / actions were.

Patient records are stored in a combination of electronic notes (EMIS) and paper notes. It was clear from reading the records that staff knew the patients very well and care and treatment appeared to be individualised and appropriate to the current needs. We had previously

recommended that life story work was completed for each patient and were pleased to see that there has been good progress in this area. We were told that this work is always offered and promoted, but some patients choose not to participate for a variety of reasons.
Some of the initial nursing assessments were very comprehensive. Most care plans were holistic, wide-ranging and patient centred, however some lacked detail by using non-descriptive phrases such as "use distraction" or "employ de-escalation techniques". More detail about what distraction techniques or de-escalation strategies work for that particular patient would be more meaningful and helpful. There was good attention to physical health care, with high dose antipsychotic therapy (HDAT) monitoring and annual physical examinations being carried out. We made a recommendation on our last visit that HDAT monitoring processes needed improvement and were pleased to see that this has been attended to.

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

Risk assessment was carried out to a high standard, there was evidence of regular review and there was a clear correlation between risk assessment and care planning. It was evident from the chronological notes and from talking to nursing staff and that they actively promote and support family involvement in the patient's life and, where appropriate, in discussion of the patient's care and treatment.

Prior to the Covid-19 pandemic informal work with carers was taking place and there were considerations into starting a formal carers' group. The logistics of this in the current climate are still under consideration but other ways to engage with carers are being explored.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. Clyde House staff have encouraged family contact as far as possible and some patients have been able to maintain telephone or video call contact where appropriate. Nursing staff told us that overall carer involvement could be improved and is currently under review. We heard from both patients and staff that advocacy input to the ward could be improved and the uptake is not good. Nursing staff are exploring ways to better engage with advocacy services are being explored.

Therapeutic activity and occupation

There is a full time psychologist who covers both Clyde House and Kelvin House and delivers a number of evidence-based therapies. These include cognitive behavior therapy (CBT) for people with psychosis, cognitive remedial therapy (CRT) and behaviour family therapy (BFT). The psychologist creates formulations and mini formulations on distressed behaviors to maximise the options for patients on discharge and also facilitates reflective practice sessions with staff.

The files we reviewed contained comprehensive OT functional assessments, OT care and treatment plans, activity planners and weekly activity programmes. We were told that OT provision for Clyde House is limited to only one day per week. For a high dependency intensive rehabilitation ward, where much of the focus will be on developing and sustaining life skills and

using specialist intervention to develop, recover and maintain meaningful patterns of activity, we find so little dedicated OT input to be of concern. It is clear that nursing staff lead on the majority of the ward based activities and this was evidenced within the patient's notes and in the activity planners. Nursing staff spoke positively about this and we saw examples of some creative and meaningful ways to pass the time, such as furniture restoration, gardening, arts & crafts, DIY groups and pet therapy. There was an activity board displayed in the corridor. Whilst this is positive, engagement in therapeutic activities is a core element of care, especially in this complex patient group and one day per week of specialist OT input is minimal.

Recommendation 1:

Managers should undertake a review of OT provision in Clyde House and ensure optimal access to specialist OT lead assessments and therapeutic activities for patients on this ward.

Use of mental health and incapacity legislation

Seven out of the 12 patients currently in Clyde House are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and five are informal. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Unfortunately there were some anomalies in the legal documentation with regards to T2 and T3 forms which authorise prescribed psychotropic medication. We raised these matters on the day and were assured they would be remedied.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') must be completed by a doctor (or suitably qualified person). The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. Unfortunately we found that s47 certificates use was inconsistent and some patients who have been deemed to lack capacity do not have a s47 certificate in place. We made a recommendation around s47 certificates on our last visit and were dismayed to see this issue remains outstanding. We were also concerned to hear that there appears to be a long standing dispute between medical staff over whose responsibility this is. In the service response to our 2017 visit we were told that a decision would be made to determine ultimate responsibility for s47 completion and for the matter to remain outstanding four years later is unacceptable. Where medical treatment is provided for which s47 authority is required, and where there is no s47 certificate to provide that authority, the treatment may be considered unlawful and care providers are placing themselves in a vulnerable position. It is therefore imperative that this matter is resolved as a priority.

Recommendation 2:

Managers must ensure all consent to treatment authorisation required under the Mental Health Act and the AWI Act accurately reflects what is being prescribed and is available with the medication charts, so staff are clear under what authority they are administering medication.

Advance Statements

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. Only one of the patients currently in Clyde House had an advanced statement. We suggested these could be better promoted and were told work in this area is being explored.

Specified Persons

Section 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied. It was apparent from discussion with ward staff and from looking at care records that there appears to be a lack of understanding about specified person legislation and there was little evidence of review or consistent application of the legislation. The Commission would therefore expect all restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

Recommendation 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.

The physical environment

The ward is clean, tidy and free from unpleasant odours. The ward benefits from a number of communal areas including a spacious sitting / dining room, several smaller sitting areas and a private garden space, which was bright, welcoming, peaceful and well maintained. We noticed that high traffic areas are looking tired, shabby and would certainly benefit from refurbishment. We were told that plans for a major refurbishment had been spoken about for a number of years (6+) however this has never been progressed. The ward comprises of six single bedrooms and three four-bedded dormitories and in this regard it is unsuitable environment for an inpatient mental health ward. Many wards across NHSGGC have been refurbished to provide patients with individual rooms and we would strongly encourage managers to consider the same here to ensure privacy and to protect dignity, especially given the fact that this particular group of patients can be in hospital for fairly lengthy periods of rehabilitation.

Recommendation 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.

Recommendation 5:

Managers should plan to provide single room accommodation to ensure maximum benefit to patients.

Any other comments

Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment, creativity and finding new ways of working. We were impressed with the way in which this service has adapted and it is hoped the positive changes that have benefitted some aspects of patient care can be continued and developed in future models of care.

Summary of recommendations

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.

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 medication charts, so staff are clear under what authority they are administering medication.

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.

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.

5. Managers should plan to provide single room accommodation to ensure maximum benefit to patients.

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.

Alison Thomson
Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

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

The 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: mwc.enquiries@nhs.scot
website: www.mwcscot.org.uk