Mental Welfare Commission for Scotland

Report on announced visit to: Cuthbertson Ward, Gartnavel Royal Hospital, Great Western Rd, Glasgow G12 0XH

Date of visit: 7 October 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 route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits, however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face to face.

Cuthbertson ward has 20 beds and provides assessment and treatment for individuals with a diagnosis of dementia. On the day of our visit the ward had ten patients, two of these were patients being boarded into the ward from other areas due to lack of beds locally. We are advised that the ward has routinely been running at less than full capacity for approximately two years.

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. There is a pleasant enclosed garden space directly accessible from the dining room. We last visited this service on 30 July 2019 and made recommendations in relation to person centred care planning and life history.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision.

Who we met with

We met with and/or reviewed the care and treatment of six patients and four relatives.

We spoke with both the charge nurses and the patient activity nurse.

Commission visitors

Mary Hattie, Nursing officer

Mary Leroy, Nursing officer

What people told us and what we found

Care, treatment, support and participation

The ward routinely has input from four consultant psychiatrists who cover the catchment area. There is regular input from occupational therapy (OT), psychology, physiotherapy and pharmacy. Input from other professionals including dietetics, speech and language therapy can be arranged on a referral basis. Social workers are involved on a case-by-case basis.

MultIdisciplinary team meetings (MDTs) are held weekly for each consultant, notes of these are recorded on the Emis electronic system. We found the quality of these inconsistent, with some lacking information on who was present and the detail around decisions taken, actions required and future plans.

We found life history information recorded within the initial assessment and completed getting to know me forms in all the patients' files we reviewed. This is a document which contains information on an individual's needs, likes and dislikes, personal preferences and background, to enable staff to understand what is important to the individual and how best to provide person centred care whilst they are in hospital.

Relatives we spoke to were positive about the care provide and the overall communication from the nursing team, however one relative commented that they had experienced difficulty in obtaining information from the consultant.

When we last visited we made recommendations in relation to care plans. On this visit we were pleased to see that within the care plans we reviewed risk assessments were documented and reviewed regularly, care plans were person-centred and addressed risk and mental health needs. Where an individual was experiencing stress and distress there was a detailed care plan which included information on the potential triggers and management strategies which have been found to be effective for the individual.

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 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 relation to the care goals, treatment and discharge of patients, and this should be audited to ensure consistent quality of record keeping.

Use of mental health and incapacity legislation

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), copies of the detention paperwork were on file. Part 16 (s235-248) 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. We found that where a T3 certificate was required to authorise treatment this was in place. However, one patient had medication prescribed which was not included on the T3. We requested that the consultant be contacted to address this.

Where individuals had granted a power of attorney this was recorded, however copies of the powers were not present in all the files we reviewed. Staff advised us that copies of the powers had been requested from the proxy decision maker and were awaited. It is important that this information is available within patient's files, so that staff are aware of the powers held and proxies are consulted appropriately.

Where a patient lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 ('the AWI Act') must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act.

We found completed s47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity and the proxy decision makers had been consulted.

Recommendation 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.

Rights and restrictions

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

Visiting is taking place in line with government guidance. Visits are booked in advance. The ward offers flexible visiting times and is routinely able to accommodate up to fifteen visits a day. We were informed that there has been no difficulty in accommodating visit requests.

Advocacy is available and visit the ward on a regular basis, patients subject to the act are routinely offered access to advocacy.

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

The ward benefits from having a patient activity nurse who co-ordinates the ward activity programme. There is a dedicated activity room which is suitable for small groups and craft activities. During our visit there were small group activities ongoing. There were activity care plans containing information on individual's interests and activity preferences and a record of activity participation and outcome within the chronological notes for each of the patients whose care we reviewed.

We were pleased to hear that it has been possible to restart some activities which had been paused during the pandemic, with both Common Wheel and another volunteer musician again providing music sessions which are greatly enjoyed by the patients. We heard that two staff have had training in playlists for life.

Since our last visit the ward has benefited from the provision of an interactive activities table, which can be used in a number of ways by patients, individually or in small groups.

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, and the artwork on the windows with pictures of old Glasgow add interest to the environment.

Summary of recommendations

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 relation to the care goals, treatment and discharge of patients, and this should be audited to ensure consistent quality of record keeping.

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.

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.

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