**Mental Welfare Commission for Scotland**

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

**Date of visit:** 16 August 2022

## Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Cuthbertson is a 20-bedded unit that provides assessment and treatment for older adults who have a diagnosis of dementia. On the day of our visit there were five vacant beds, and four patients were boarded in from other sectors.

We last visited this service on 7 October 2021 and made recommendations in relation to T3 certificates and the need to ensure the quality of MDT review notes. The response we received from the service was that both issues were addressed. A checklist was introduced to ensure consistency in the quality of MDT review notes and there was ongoing audit to ensure that there was compliance with the T3 certificates.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how the service was changing in response to the reduction in Covid-19 restrictions.

### Who we met with

We met with, and reviewed the care of ten patients, seven who we met with in person and three whose care notes we reviewed. We also spoke with four relatives.

We spoke with the in-patient operational nurse manager, the professional nurse lead, the senior charge nurse, the charge nurse and the occupational therapist (OT).

### Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

Justin McNicholl, social work officer

# What people told us and what we found

## Care, treatment, support and participation

Throughout the visit we saw kind and caring interactions between staff and patients. Staff we spoke to knew the patient group well. The relatives who spoke to us were all very positive about the staff team who they described as compassionate and caring. We heard that they felt staff made time to spend with patients and relatives, despite being very busy. We were told that "care has been exceptional and communication with doctors and nurses has been excellent", and "when the medical staff were adjusting medication they would always discuss it with me and give me the rationale for their decisions, I found this helpful".

We also heard a number of positive comments about individual team members and about how staff dealt calmly and positively with difficult situations. One relative explained the impact of taking their father into hospital and told us that "the staff not only supported my father, but they helped me too". We heard that "the staff team are kind and respectful not just to my father, I see how they interact with other patients too".

### Multidisciplinary team (MDT)

The unit has input from four consultant psychiatrists, as well as the nursing staff, occupational therapy staff, psychology staff, physiotherapy staff, a patient activity co-ordinator and pharmacy staff. Referrals can be made to other allied health professionals as required. The ward has a number of registered nurse vacancies and is using bank and agency staff to maintain staffing levels while these posts are recruited to. We heard that four new staff nurses have been recruited and will be starting over the next few weeks.

The MDT meeting notes indicated that everyone involved in an individual's care and treatment is invited to attend the meetings, and the minutes contain a clear record of the patient's progress, the decisions that are taken and actions required. There is evidence, both in the notes and from our discussions with relatives, that proxy decision makers and carers are involved in these discussions.

We were told that there are four patients currently awaiting care home placements and whose discharge is considered to be delayed. Specialist equipment and care home placements that can meet the patient's particular needs are actively being pursued.

### Care records

Information on patient care and treatment is held mainly on EMIS, the electronic record system, however care plans are still in paper files. The ward has very recently commenced using the HEPMA electronic prescribing system. Staff commented positively on the ease of use and the efficiency of this system.

We were told that risk assessments are carried out on admission and again after 72 hours, with updates being documented as required. These are contained in the chronological notes on EMIS, making them difficult to locate. We discussed with the senior charge nurse the benefits of storing all risk assessments in the assessment section of EMIS, making it easier to locate these, to chart progress and ensure updates are being completed.

In the patient records we reviewed, we found a number of person-centred care plans, including plans for stress and distress, activity, physical healthcare and personal care. However the quality of the information and level of detail contained in the care plans was inconsistent, with some good examples of person-centred care plans with a focus on maintaining skills, and some requiring further development as they did not fully reflect the complex needs of the patient, or the person-centred care that was being provided. We did find evidence of patient involvement in care planning.

We were unable to locate care plan reviews containing information on the effectiveness of nursing intervention and individual's progress. We discussed this with the senior charge nurse and charge nurse. There was an acknowledgement that, over recent months this had not occurred and needed to be addressed. We were told this was due to the ward working with reduced numbers of registered staff for a period of some months, but that this issue should be addressed with the new registered nurses who are due to start.

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/node/1203

We were pleased to see that the majority of patients whose care we reviewed did have a Getting to Know Me on file; however the level of information these contained varied considerably, with some containing very little detail about the individual. 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. 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.

**Recommendation 1:**
Risk assessments should be located in the assessment section of EMIS for ease of access and review.

**Recommendation 2:**
Managers should review their audit processes to improve the quality of care plans to ensure these are consistently person centred, reviews are undertaken and care plans updated to accurately reflect the patient's current needs and planned interventions.

**Recommendation 3:**
Managers should regularly audit the Getting to Know Me documentation to ensure this is fully completed and life history information is recorded and follows the patient when they move to a further care placement.

## Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) copies of detention paperwork were on file. Part 16 (sections 235-248) 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. Certificates authorising treatment under the Mental Health Act were in place, where required, and covered all prescribed treatment.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), this was recorded. However not all of the files we reviewed contained copies of the powers held by the proxy.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of AWI legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found completed section 47 certificates and treatment plans in the notes of the patients that we reviewed, and who lacked capacity; we noted that consultation with proxy decision makers had been recorded.

For patients who were receiving covert medication, this was highlighted on the HEPMA system and a covert medication pathway had been completed.

**Recommendation 4:**
Managers should ensure that where a power of attorney or guardianship is in place, copies of the powers granted are held on file.

## Rights and restrictions

Cuthbertson ward continues operates a locked door, this is commensurate with the level of risk identified in the patient group. Information on how to gain access and leave the ward was available and there is a locked door policy in place.

Following repeated ward closures due to Covid-19, the ward has re-introduced a booking system for visits. Visits are restricted to the dining and interview room, and visiting hours are 10am until 8pm, excluding mealtimes. The ward can accommodate 18 visiting slots each day and we are told by staff that this has been well received by carers, however one relative did express concerns at the restrictions on visits. We highlighted this to the senior charge nurse and asked that restrictions be kept under review.

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 are aware that during the pandemic, restrictions put in place had meant that various activities out with the unit had to be put on hold. However, we heard about the efforts of the patient activity co-ordinator and occupational therapy staff to ensure there is always activity available on the unit for patients. The patient activity co-ordinator and nursing staff undertake a range of small group and individual activities with patients on an ad-hoc basis, including quizzes, newspaper groups, reminiscence sessions, gardening, crafts, and pamper sessions. The occupational therapist and psychologist run cognitive stimulation therapy groups on a weekly basis.

We also heard that a number of externally provided activities have re-commenced, including music sessions by the common wheal and other ad-hoc musical events, as well as therapet sessions, gardening and mosaic making sessions arranged by the volunteer co-ordinator.

Now that restrictions are reduced and patients are once again able to resume community activities, patients are supported to participate in accessing the local community, going for walks or outings to local cafes.

## 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 has pictures of old Glasgow that add interest to the environment. The ward has two secure garden areas directly accessible from the ward area. It also benefits from having a dedicated activity room and a quieter room which houses an interactive table. We heard that new chairs, curtains and sensory equipment have been ordered for this room, but that delivery of this, along with new garden furniture had been delayed for several months. We look forward to seeing the new equipment and furniture in situ during our next visit.

## Summary of recommendations

**Recommendation 1:**
Risk assessments should be located in the assessment section of EMIS for ease of access and review.

**Recommendation 2:**
Managers should review their audit processes to improve the quality of care plans to ensure these are consistently person centred, reviews are undertaken and care plans updated to accurately reflect the patient's current needs and planned interventions.

**Recommendation 3:**
Managers should regularly audit the Getting to Know Me documentation to ensure this is fully completed and life history information is recorded and follows the patient when they move to a further care placement.

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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.

Claire Lamza
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 Commission 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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