Mental Welfare Commission for Scotland

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

Date of visit: 11 October 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.

Iona House provides 20 continuing care beds for older men and women with complex care needs. On the day of our visit only seven beds were occupied. We were advised that the ward had a Covid-19 outbreak during the second wave, resulting in a number of patient deaths. The ward has continued to function significantly below capacity since this time despite accepting referrals from admission wards in both the west and north of the health board area. We were informed that bed capacity is currently under review as part of the ongoing review of older adult mental health services.

We last visited this service on 12 March, 2020 and made recommendations in relation to recording of activity provision, proxy decision makers and care planning. The response we received from the service was that all of these were addressed through audit and review.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the current pandemic as our previous visit had occurred prior to the first Covid-19 lockdown.

Who we met with

We met with, and reviewed, the care of seven patients, five who we met with in person and two whose care notes we reviewed.

We spoke with the senior charge nurse and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing 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 that we spoke with knew the patient group well.

The ward has regular input from psychiatry, occupational therapy, pharmacy and physiotherapy and other allied health professionals are available on a referral basis. GP cover is provided from Monday to Friday. Outside these hours medical cover is provided by the duty doctor rota. Multidisciplinary team (MDT) meetings are scheduled weekly, and are attended by the consultant psychiatrist, nursing staff and psychology.

MDT reviews were well documented, with clear actions and outcomes, and proxy decision makers and family involvement noted in discussions about future placement and treatment thresholds. Risk assessments were regularly reviewed and updated.

We had previously made a recommendation in relation to recording life history information as this is essential to the development of person-centred care plans and the delivery of person centred care. We found fully completed Getting to Know Me forms in all the patients' files. This is a document which records a person's needs, likes and dislikes and background, and is aimed at helping hospital staff understand the person and how best to provide person-centred care. The information contained in these had been integrated into each patients care plan, ensuring that the care delivered was truly person-centred. The chronological notes and the care plans provided good evidence of how well staff knew their patients and we found these to be thoughtful and creative in delivering care that met their patient's needs.

We found care plans for the management of stress and distress that provided information on triggers, strategies for de-escalation and distraction that had been found to work for the individual. Some of these were based on a Newcastle formulation, which is designed to assist staff in understanding and responding to the individual's behaviours. All of these referenced information contained in the Getting To Know Me document; it was clear that considerable thought had gone into developing these. However in number of these care plans the language used was inconsistent, at times labelling behaviour as aggression and violence, rather than acknowledging the stress and distress which underlies these behaviours.

Where a person who cannot consent to a decision about cardio pulmonary resuscitation (CPR), it is a requirement to consult with any appointed proxy or close family, as well as trying to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. In all the care files we reviewed which contained 'Do not attempt CPR' (DNACPR) forms, there was evidence of discussion with nearest relative or proxy as appropriate.

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

Recommendation 1:
Managers should audit care plans to ensure there is consistent use of appropriate language.

Use of mental health and incapacity legislation

On the day of our visit three of the seven patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Where individuals were subject to detention under the Mental Health Act, the current detention paperwork was present in the files. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are incapable of consenting to specific treatments. Certificates authorising treatment (T3) were in place where required, and covered all of the medication being prescribed.

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. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. All the patients whose care we reviewed lacked capacity to consent to treatment. In each case there was a completed s47 certificate and treatment plan, and proxy decision makers or relatives had been consulted appropriately.

Where individuals had granted a power of attorney, or had a guardianship in place, this was recorded, and a copy of the powers was held in their care file.

For patients who were receiving covert medication, a covert medication pathway authorising this had been completed and review dates were recorded.

Rights and restrictions

Iona house operates a locked door, in line with the level of vulnerability of the patient group. Staff control entry and exit to the ward via a keypad, and there is a locked door policy in place, however this information was not visible in the ward.

Information about the local advocacy service is available and we are advised that they respond positively to referrals, however at the time of our visit no-one was making use of this service.

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

Recommendation 2:
Information on the locked door policy and how to gain access or exit the ward should be displayed in the vicinity of the ward entrance.

Activity and occupation

The ward has regular input from occupational therapy staff who attend several days each week. Whilst there is no dedicated activity co-ordinator, activities are provided by both occupational therapy and nursing staff. Now that restrictions are lifting, the ward is once again benefiting from outside volunteers providing music sessions, and it is hoped that pet therapy will recommence soon. We saw evidence of music groups, reminiscence work, pamper sessions and walks in the grounds in the notes we reviewed. During our visit, we observed

staff spending time chatting with patients and engaging in activities. We found person-centred activity plans for all of the patients and activity participation and outcomes of this were recorded in the chronological notes.

The physical environment

The ward has a homely lounge as well as a quiet sitting area and a spacious, bright dining area. Sleeping accommodation is a mixture of single rooms and small dormitories. The ward is clean, bright and well maintained and bedroom areas are personalised with patients own covers, pictures and personal effects, creating a homely atmosphere and aiding orientation. The atmosphere on the ward was calm, welcoming and friendly.

We were told that following discussions with the physiotherapist infrared beam alarms will shortly be installed in dormitories and bedrooms with a view to reducing falls and improving patient safety. We look forward to hearing about the impact of this development when we next visit.

There is access to a small secure garden area which has recently been landscaped and is used regularly by a number of patients; the garden is being maintained by volunteer gardeners. Patients who can enjoy longer walks have access to the wider grounds of Gartnavel Royal Hospital.

Summary of recommendations

Recommendation 1:
Managers should audit care plans to ensure there is consistent use of appropriate language.

Recommendation 2:
Information on the locked door policy and how to gain access or exit the ward should be displayed in the vicinity of the ward entrance.

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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