Mental Welfare Commission for Scotland

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

Date of visit: 22 June 2023

Where we visited

Claythorn House is a mixed-sex 12-bedded acute assessment and treatment unit for individuals with intellectual disability and mental ill health, based on the Gartnavel Royal Hospital site.

We last visited this service on 19 October 2021 and made recommendations about care plan reviews and the replacement of a bath. On this visit, we wanted to follow up on the previous recommendations as well as look at the care and treatment being provided in the unit.

Who we met with

We met with and/or reviewed the care and treatment of seven patients. We spoke to the family members of three patients.

We spoke with the service manager, the senior charge nurse (SCN) and one of the consultant psychiatrists.

Commission visitors

Margo Fyfe, senior manager, west team

Sheena Jones, consultant psychiatrist, west team

What people told us and what we found

Care, treatment, support and participation

On this visit, there were 12 patients in the unit. Three of the patients were considered to require assessment and treatment. The remainder of the patients either were in the process of discharge or considered to be delayed discharges. For the nine patients identified as delayed discharges we will contact the social work teams involved to seek clarity as to progress and to ensure that patients, families, and carers are actively involved.

We were advised that there were eight patients on the waiting list for admission, some who have been waiting in general psychiatric services and some waiting at home.

At the time of the previous visit, it was noted that two beds were vacant allowing for greater space in the inpatient environment. All beds are now occupied and there has been a significant increase in delayed discharges. This has resulted in a busier environment with less flexibility around the use of space. It has also been reported to increase the risk of interpersonal violence.

What we did hear from families that we spoke with were their positive views about the care and treatment that their relative receive in the ward and the positive relationships that they have with the multidisciplinary team. One family said that they "were more than happy with care". They said, "staff are more than good" to (their family member) and to the parents. Two families noted that they felt welcome in the ward. One family highlighted concern about the lack of information from the social work team regarding their relative's discharge planning, where the discharge was already delayed.

Care plans

We heard that the service is currently piloting the use of electronic care plans with the intention that this will be in place for all patients in Claythorn House in due course. This is occurring in the context of a wider plan to move towards paperless records. At present, the service is in the process of creating templates for their documentation and it was noted at the time of our visit that there was still a hybrid model with a combination of paper and electronic records. We were told that the electronic care plans were not felt to be at the level that is intended and that there is ongoing work regarding this.

We reviewed a range of paper and electronic care plans in the electronic patient record from nursing, psychology, speech and language therapy and occupational therapy. We found the positive behaviour support plans to be detailed, informative and to be written in line with Commission guidance.

We did not think that the nursing care plans had the level of detail that we would expect, particularly with regard to goal setting, review of progress, acknowledging achievements and responding to changes. We would also want to see the involvement and participation of patients, their families and carers in the care planning process; there was little evidence of this at the time of our visit.

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

We would recommend using the above guidance to help in developing care plans and reviews and look forward to reviewing progress at a later date.

Two patients spoke to us about limits placed on their time out of the ward on the day after they had had incidents where they had been agitated and aggressive. We reviewed their care plans regarding this, and noted that there were indeed limits placed on patients on the day after a significant incident without any detail as to the rationale for this. We discussed this with the multi-disciplinary team who advised us that the restrictions were required to reduce the risk to patients and staff from a higher numbers of incidents occurring on the day after a significant incident, rather than the restrictions being intended as a negative consequence or punishment. We would suggest that such risk assessment/ management considerations should be explicitly detailed in the care plans.

Recommendation 1:
Managers should review care plan documentation to ensure that patients' care plans reflect good practice guidance.

Recommendation 2:
Managers should ensure that care plans provide a clear rationale regarding any limits or restrictions placed on patients as part of risk assessment and management strategies.

Multidisciplinary team (MDT)

Staff retention is an issue with a number of qualified nursing staff having left in recent months. Newly qualified staff nurses will take up post later in the year but will not have the same level of experience. Staffing levels across the learning disability site were noted to be an issue with two members of staff from Claythorn House providing cover to another learning disability unit on the day of our visit. Bank staff often provided cover in the ward. In general, the bank staff were regular members of staff who were familiar with the ward and patient group.

Sessional time was provided by two consultant psychiatrists, psychology, occupational therapy, speech and language therapy, dietetics and physiotherapy. A Band 7 occupational therapist has recently been appointed to the learning disability service. The pharmacy position in the team was noted to be vacant, however there was interim cover that was readily accessible. There was an activity nurse in post, and this has been valuable in providing activities on an individual and group basis. There is also a change manager in post who has supported multidisciplinary sessions involving patients, families and carers that have been established to think about positive outcomes for people whose discharge is delayed.

The unit has access to 24-hour on-site psychiatry cover through the duty system at Gartnavel Royal Hospital. GP input and GP urgent medical cover was provided during normal working

hours. Urgent medical and psychiatric cover out with normal working hours was provided by the duty doctor at Gartnavel Royal Hospital.

We were pleased to hear that the ward team have recently introduced a new multidisciplinary meeting template and we reviewed a number of these in the patients' electronic records. We found the completed meeting records to be detailed and supporting forward planning. It was also noted that a positive outcome of the recent pandemic was the increased use of technology to support multidisciplinary attendance at the team meetings.

Use of mental health and incapacity legislation

At the time of the visit all twelve patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act). Nine patients were subject to guardianship under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') and there were applications in progress for the remaining three patients.

We found all legal documentation, including consent to treatment forms, in place and readily available in the electronic record for patients subject to Mental Health Act provisions.

Welfare guardianship paperwork was not yet available in the electronic records, however this would be valuable in ensuring easy access for staff when consulting with guardians as needed. AWI paperwork (section 47 certificates and treatment forms) was also not available on the patients' electronic files. While these were kept in a separate folder in the treatment room, they were easily accessed.

Rights and restrictions

At the time of our visit, two patients had seclusion care plans in place, with seclusion having recently been discontinued for a third patient. Seven patients were subject to enhanced levels of observation and two patients had an identified 'responder' (a key worker for them each day). There was little information evident in the paper or electronic files regarding care planning for enhanced levels of observation. We look forward to seeing more detail regarding this when we next visit.

The ward has a locked door policy in place that is available to view on request. The door was locked due to the vulnerability of the patient group. There were individual detailed risk assessments in place for patients that outlined arrangements for time off the ward and support required to facilitate this safely.

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

There continued to be a dedicated activity nurse in post who ensured that patients had individual activity planners, including a range of social, recreational, and rehabilitation activities. The activities offered were delivered both in the ward and in the community, supported by staff where appropriate. Regular ward activities included music and art therapy, cooking and baking activities, walking groups and film nights. There had been a recent themed

activity relating to Scottish learning disability week and Pride. We saw photographs relating to themed activities that have occurred in recent months decorating the ward with evident enjoyment and participation from those who took part.

The garden space was a colourful and engaging place to be, and patients were enjoying activities in the garden during our visit. Patients were also able to enjoy the wider hospital grounds in recent weeks with the good weather and had been enjoying walks and sports activities.

The physical environment

In general, we found the unit to be plain, clinical and lacking a homely feel, which was a concern, given the increase in delayed discharges and that patients were spending far longer in the unit. The staff team advised us that patients were able to make their rooms more personal with some of their own possessions. It was also noted that in some cases, patients could not manage having a lot of things around when they were feeling overwhelmed.

We had noted at previous visits that the acoustics in the unit are unsuitable for patients, with noise reverberating around the corridors and in the activity and living areas. Many patients with developmental disabilities have specific sensory needs and the current noise levels must be difficult to manage. Two patients that we spoke to said that the noise at night makes it hard to sleep.

With the unit being fully occupied, this has meant that there is less flexibility in the environment and there were fewer vacant rooms which can be used as extra activity or visiting spaces.

Staff told us that there has been an increase in interpersonal risk in the ward. We recognise that the noise levels, increased patient numbers and reduced flexibility in the environment will all be important factors in this.

An additional issue we noted was with a broken control panel, which the staff team no longer had access to. The control panel had previously allowed the nursing staff to isolate electricity and water supply to individual rooms depending on the specific needs of each patient.

We were pleased to note that our previous recommendation about the broken bath had been actioned, and this has since been replaced.

Recommendation 3:
Managers should ensure that the intended work to soundproof and better manage noise levels in the ward continues to be prioritised.

Recommendation 4:
Managers should urgently review the broken control panel, which allows the nursing team to manage electrical and water supply to individual rooms to ensure patient-centred care.

Summary of recommendations

Recommendation 1:
Managers should review care plan documentation to ensure that patients' care plans reflect good practice guidance.

Recommendation 2:
Managers should ensure that care plans provide a clear rationale regarding any limits or restrictions placed on patients as part of risk assessment and management strategies.

Recommendation 3:
Managers should ensure that the intended work to soundproof and better manage noise levels in the ward continues to be prioritised.

Recommendation 4:
Managers should urgently review the broken control panel, which allows the nursing team to manage electrical and water supply to individual rooms to ensure patient-centred care.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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