Mental Welfare Commission for Scotland

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

Date of visit: 4 September 2024

Where we visited

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

At the time of this visit, there were 10 people in the ward. Three were considered to require active assessment and treatment; the remainder were ready for discharge or considered as a 'delayed discharge'. There were four people waiting for admission to the unit, all of whom were inpatients in general psychiatry settings.

We were told that two bedrooms had been temporarily closed. One of the bedrooms had been made into an additional meeting room. The need for office space was identified as a priority after a recent review of two medication errors.

The second room is in the process of being adapted to be a low stimulus room for people in the ward to use. A reduction in the number of beds was also felt to be important as at times when the ward is noisy and busy, there have been increased levels of interpersonal aggression.

We last visited this service in June 2023 and made four recommendations which related to care plans, care plan reviews, issues with sound proofing and a broken control panel. We heard from the service about the actions that they had taken to address these recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and, also to look at progress towards discharge for the people who had been identified as delayed discharges.

Who we met with

We met with and reviewed the care of six people, four that we met with in person, and we reviewed the notes of another two people. We also spoke with one relative.

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

During our visit we also had the opportunity to look around the ward and speak to members of the nursing team.

Commission visitors

Dr Ahmad Allam, higher trainee

Mary Hattie, nursing officer

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

The people that we spoke to were very positive about the care and treatment that they received from the care team. One person told us “my nurse looks after me” and spoke about the care they would need to enable them to leave hospital.

We saw caring and supportive interactions between people and the care team. One individual was highly distressed on the day of our visit, and we saw a calm and professional approach to supporting this person.

We heard from the people that we spoke to that the ward can be “really noisy”. One person said that this “makes it difficult to rest”. The care team agreed that the size and layout of the ward means that it can be noisy and busy and that this can increase people’s distress and levels of frustration.

One family told us that their relative had been in Claythorn Unit for several years. They said that the staff team were very supportive, responded quickly to any incidents and that they “could not fault them at all”. They also said that they had known the psychiatrist for a long time and that they were very good at keeping them informed. While they had no concerns about the care of their relative, they too felt that the unit was very noisy and busy and that this was difficult for everyone there.

One person said that he was bored in hospital and wanted his own flat. The care team also spoke to us about delays in people leaving hospital, even when they were considered ready for discharge. We were advised that there could be delays in people being allocated social workers and in the funding of community support packages for discharge.

We heard that one person had a package of care in place, but the funding was not approved. We heard that for another, who had been in hospital for over 3 years, their funding approved had not yet been approved even though their complex needs were well established; this was causing them significant frustration and distress and had led to a deterioration in their mental health. We have been in contact with the local authority and will continue to monitor progress with regards to these issues.

We were told that there were no outstanding complaints or significant incident reviews at the time of our visit.

Care, treatment, support and participation

During this visit we were keen to explore what progress had been made with care plans given our previous recommendations about this. We heard from senior staff that since our last visit the service had changed from electronic care plans to paper care plans. This happened because the electronic care plan template was not felt to be suitable. There is ongoing work across the service with regards to the development of a new electronic care plan template.

Care records

The service at Claythorn House uses an electronic record management system, EMIS and an electronic medication prescribing system, HePMA, in addition to paper files.

We were readily able to access information on the electronic systems and in the paper care files. On both electronic systems there were helpful alerts highlighting important information about individuals' mental and physical health, any legal processes that were in place and any specific risks or concerns.

We found that there was a wide range of detailed and person-specific care plans in place for each person relating to physical health, mental health, developmental needs, communication, positive behaviour support and behaviour management strategies.

We saw a range of care plans and information in each person's notes that ensured that the care team had a good knowledge and understanding of them. This included 'Pen Portraits' (a one- or two-page description of the person with key information about them), 'All About Me' documents and Hospital Passports (containing information that would be needed should the person need to go a general hospital).

We could see that the views of the individuals were considered through the care plans. This varied from people signing their own care plans, records of discussions of the contents of the care plan and for individuals with severe learning disability who had no verbal communication, their preferences, interests and choices were included.

In some care records, we saw accessible care plans in the form of pictures or stories.

In all the care plans that we reviewed we saw a clear record of when the care plan was reviewed, of any changes that were made and the rationale for this.

In the electronic records we reviewed, the daily progress notes and minutes of the weekly multidisciplinary meetings and less frequent formal 'Care Programme Approach' meetings, these involved all members of the health and social care team. These records provided detail about the person's activities each day, their one-to-one meetings with their named nurse, their involvement in meetings and communication with, and contribution by, family members and carers.

In addition to the care plans described above, we saw a range of information about each individuals' developmental, behavioural, communication and sensory needs. It was clear from this that a range of professionals were contributing to care and treatment, with regular occupational therapy (OT) and speech and language therapy assessments and recommendations in place.

Psychological input was also recorded, with detailed psychology assessments, positive behaviour support plans and behavioural strategies in the format of a 'traffic light system' that detailed how each person should be supported at any given time, depending on how they were feeling.

We saw a wide range of risk assessment and management details that linked with the care plans and the psychological strategies that were in place.

With regards to physical health, we found that there was a range of relevant care plans in the records that we reviewed. We also heard that there had been a recent piece of work completed by the NHS Greater Glasgow and Clyde health check team. People in the ward were reviewed by this team using the standard annual health check documentation that has been rolled out across Scotland. It was positive to hear that no significant additional physical health needs were identified following this piece of work.

Multidisciplinary team (MDT)

The unit is staffed by NHS nurses. Staff retention has continued to be an issue in the unit, leading to the ongoing use of bank staff. The closure of another unit in the learning disability service later this year will be helpful with experienced staff from there moving to work in Claythorn House. Wherever possible experienced bank staff who are familiar with the care and treatment needs of the people in the unit are used.

In addition, there was a daily service huddle when the staffing complement across the service was reviewed, and this included the mix of regular and bank staff.

Sessional time was provided by two consultant psychiatrists, psychology, occupational therapy, speech and language therapy, dietetics, pharmacy and physiotherapy.

The multi-professional approach to care and treatment was evident across the care records that we reviewed.

There was an activity nurse in post, and this has been valuable in providing activities on an individual and group basis. We heard that activities in the ward and in the community are prioritised wherever possible, and this was evident from care records, in discussion with people and staff and from the photos and information around the ward.

The unit has access to 24-hour, on-site psychiatry cover through the duty system at Gartnavel Royal Hospital. There was input from a GP three times a week and GP urgent medical cover is provided during normal working hours. The visiting GP knew the people in Claythorn House well, and this continuity was found to be valuable. Urgent medical and psychiatric cover out with normal working hours was provided by the duty doctor at Gartnavel Royal Hospital.

We reviewed daily progress notes, weekly multidisciplinary meeting minutes and minutes of other health and social care meetings. These detailed the involvement of the person, the families and carers and multi-disciplinary team members.

There were clearly recorded action points in the minutes of meetings. In some cases, people were supported in their meetings by advocacy services.

Of the seven people in Claythorn House who were ready for discharge, only one person had a complete discharge plan. Another had only recently been allocated a social worker. We heard from social work managers that with recent recruitment, one person who did not have a social worker would be allocated one soon. Two people's discharge plans had been delayed by a lack of funding approval.

Four people had no discharge plan but there was ongoing work via multidisciplinary discharge meeting processes (called 'Macro meetings') to try to identify appropriate accommodation and support providers.

We will continue to monitor progress for all people identified as being ready for discharge.

In some cases, we heard that there had been additional health and social care team peer review meetings. Peer review meetings were held when there has been a lack of progress regarding the care and treatment of people with complex care needs and a more tailored approach may be required for that person.

Use of mental health and incapacity legislation

At the time of our visit eight people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and nine people were subject to guardianship orders under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All documentation relating to the Mental Health Act and the AWI Act, including copies of guardianships were in place, reviewed and correct. These documents were held in paper form in a folder in the unit which allowed them to be accessed easily and reviewed. The electronic systems also had helpful alerts to ensure that the care team were aware that there were legal powers in place.

We heard about one recent incident which had led to the completion of an adult concern form under Adult Support and Protection (Scotland) Act. We had already been notified about this incident by the relevant social work team. There was a lack of clarity as to the outcome of the concern at the time of this visit. We will follow this up with the social worker involved.

We saw evidence through care records and daily progress notes of the involvement of people and families in care planning and the involvement of advocacy to support people with meetings when this was requested.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required, corresponded to the medication being prescribed and were in date.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. At the time of our visit, eight people had a s47 certificate in place, and we were able to review these and the corresponding treatment plans. We found them to be detailed, with each individuals' specific care and treatment, of good quality and in date.

Rights and restrictions

The ward had a locked door policy in place that was available to view on request. The door was locked due to the vulnerability of the patient group.

We were told that there had been an increase in the level of interpersonal aggression in Claythorn House. This was thought to relate to a combination of factors including the mix of individuals in the ward, their individual clinical and behavioural needs and factors relating to the ward environment. As discussed above, two beds in the unit had been temporarily closed for this reason. We also heard about plans to move individuals from Claythorn House to Blythswood House in Renfrew. This was to allow the multidisciplinary team to create bespoke areas for individuals whose mental health and behavioural needs could not easily be met in Claythorn House due to the layout of the building.

There were individualised and detailed risk assessments in place for patients which outlined arrangements for time off the ward and the support required to facilitate this safely. We saw good evidence that people were regularly supported to take part in a wide range of activities out with the ward.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found that all paperwork was available in the folder containing all legal documentation.

At the time of our visit, four people were assessed as requiring an increased level of observation, with three people having one-to-one support and one person requiring two-to-one support from the nursing team.

Additionally, three people were allocated a 'responder'. This was an identified member of staff for an individual who may need additional support at various points throughout the day. We reviewed care plans regarding the need for increased observation practice and found them to be person-centred, with a clear rationale for the restriction being in place, and with regular reviews documented.

Two people in the ward were also subject to periods of seclusion in their bedrooms at times of significant distress and agitation. We reviewed the seclusion care plans and found them to be clear regarding the seclusion process and regularly reviewed. The use of seclusion was considered in conjunction with risk assessment and management plans, positive behaviour support plans and the traffic light systems referred to above.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not see any advance statements at the time of our visit, due to the majority of people in the ward having been considered to lack capacity under the AWI Act.

The Commission has developed *Rights in Mind*[1]. 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.

Activity and occupation

The service continued to promote a culture where regular activities, including outdoor activities, were prioritised. There was a dedicated activity nurse in post who ensured that there were individual activity planners, and that they included a range of social, recreational, cultural, and rehabilitation activities.

There was a daily staffing huddle, and it ensured that activities could happen as a priority of this meeting. We saw good evidence about people's engagement in a range of activities during our visit to the ward.

Regular ward activities included music and art therapy, cooking and baking activities, walking groups and film nights. An art therapist from Project Ability visited the unit twice a week. A singer visited twice a month, and this activity was also open to

[1] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

people from Blythswood and Netherton Units. There were regular themed activities with a recent week celebrating south Asian heritage.

People from Claythorn House could also take part in activities at Blythswood House and we saw a recent stop-go animation that had been created with support from Theatre Nemo.

We also heard that one of psychology assistants had recently undertaken a health and wellbeing survey to consider people's wider health and levels of activity. There was a daily yoga session for 10 minutes each morning and other activities included baking and bracelet making.

The physical environment

Claythorn House is a large building that has staff rooms at the main entrance. In the middle of the ward is a large area which includes the dining area and lounge space, a separate TV room, a therapy kitchen and some office space. At the far end of the ward is the bedroom area, with bedrooms running along both sides of the corridor. Each person has their own bedroom and en-suite area.

There is an enclosed garden area running along one side of the building. It is well maintained and contains a number of sensory activities.

People can also go out into the grounds of the hospital for walks and group activities, in addition to their community activities.

Around the ward we saw photos and pictures relating to activities that people had recently taken part in.

Claythorn House has high ceilings, and any noise tends to travel right through the building. This was evident during our visit and was something that everyone raised as a concern.

The ward environment is not felt to adequately meet the needs of the diverse group of people that it needs to accommodate, but it was positive to hear some of the changes that had been made to try to address this, such as the reduced bed numbers, the creation of a low stimulus room and the continued focus on activities.

At our previous visit we made two recommendations relating to the ward environment. We made a recommendation that the intended work on sound proofing in the ward should be prioritised. We heard from the service manager that the sound proofing work that we discussed at our last visit has continued to be progressed. We look forward to hearing about the completion of this work, given the noise that is evident in the ward and the impact that this has on everyone.

With regards to the second recommendation to review the broken control panel (which allows the team to control electrical and water supply to individual rooms) we

were told that this has been escalated to senior managers due to risks relating to infection control. There is an infection control meeting planned for September 2024. In the meantime, the nursing team can contact the estates department to turn off electrical and water supply when needed.

Recommendation 1:
Managers should ensure that the intended work to soundproof and better manage noise levels within the ward continues to be prioritised.

Summary of recommendations

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Managers should ensure that the intended work to soundproof and better manage noise levels within the ward continues to be prioritised.

Good practice

Claythorn House has been accredited through the Accreditation for Inpatient Mental Health Services (AIMS) by the Royal College of Psychiatrists, which requires a range of good practice standards to be met.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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