Mental Welfare Commission for Scotland

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

Date of visit: 19 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. This local visit was able to be carried out face-to-face.

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

At the time of this visit there were nine patients one of whom was on pass moving towards discharge. The ward was expecting one admission later in the week from the local intensive psychiatric care unit.

We last visited this service on 17 December 2019 and made recommendations in regard to care plan reviews and enhanced observations.

On the day of this visit we noted that 10 beds are in use regularly, allowing two beds to be kept for patients who require more space in order to be managed more safely. We wanted to follow up on the previous recommendations and also look at how the patients and ward staff have managed throughout the pandemic.

Who we met with

We met with and/or reviewed the care and treatment of seven patients. Unfortunately no carers/relatives/friends took the opportunity to speak with us on this occasion.

We spoke with the service manager, the senior charge nurse (SCN) and one of the consultant psychiatrists who is also the clinical director for learning disability services.

Commission visitors

Margo Fyfe, Senior Manager (Practitioners) West Team

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Multidisciplinary Team (MDT)

The unit is staffed by NHS nurses with sessional time provided by two consultant psychiatrists, psychology, occupational therapy, speech and language therapy, and physiotherapy. There is good input from pharmacy who attend MDT meetings regularly. There is one activity nurse providing input but she has at times had to be used to supplement ward staffing numbers when needed during the pandemic. Dietetics have one day per week across the intellectual disabilities service but not always available due to demand for service and small number of staff. 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 is provided during normal working hours. Urgent medical and psychiatric cover out with normal working hours is provided by the duty doctor at Gartnavel Royal Hospital.

We were pleased to see the continued involvement of the above disciplines in MDT meetings and that where appropriate families are invited to attend via online meetings or in person. It was also good to see that patients are given the choice to attend.

The pharmacy notes and guidance seen in the medical prescription folder was detail and current.

Care plans

We took the opportunity to look at seclusion care plans and behavioural care plans. We found both to be detailed, informative and to be written in line with Commission guidance.

On our last visit to the unit we made a recommendation that managers should audit the process for reviewing nursing care plans which reflect progress towards goals, acknowledge achievements and respond to changes. On this visit we found that care plans were indeed more focussed and person centred. We found that patients we spoke with were aware of their care plans and that where appropriate easy read versions had been provided.

However, we found that care plan reviews were poor. Nurses did not always sign and date reviews or care plans. Given the complexity of the care provided and the function of the ward being assessment and treatment, we would expect these reviews to be more robust, identifying progress and targeting nursing intervention to continue this progress. We are making a recommendation in this regard and expect to see progress in this area at the time of our next 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.

Recommendation 1:

Managers should urgently review the care plan documentation and ensure all nurses are aware of how to complete these appropriately.

Use of mental health and incapacity legislation

At the time of the visit there were eight patients subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act) and five patients subject to guardianship under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

We found all legal documentation including consent to treatment forms easy to locate and in place for patients subject to Mental Health Act provisions.

Guardianship paperwork was difficult to locate. As staff need easy access to a record of the guardianship powers in place in order to consult guardians as appropriate, we would advise having a clear note of these powers held in the paper files. The Commission has produced a checklist for this purpose that can be found here:

https://www.mwcscot.org.uk/search?keys=guardianship+powers&op=submit

Rights and restrictions

During our last visit we commented and made a recommendation around observation levels; Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

On this occasion we found this much improved and saw detailed reviews where enhanced levels of observation were in place.

The ward has a locked door policy in place that is available to view on request. The door is locked due to the vulnerability of the patient group. There are individual detailed risk assessments in place for patients which outline 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

As at the time of our last visit we found that there continues to be a dedicated activity nurse post and this post is effective in ensuring that patients have individual activity planners which covered social, recreational, and rehabilitation activities. The activities on offer are delivered both within the ward and in the community, supported by staff where appropriate. These include access to art therapy, walking groups, daily cooking/baking groups, film nights, and

various seasonal activities. We were told that during the pandemic, activity outwith the ward had ceased but was once again becoming available to patients again. We were pleased to hear that the art therapist had managed to continue offering sessions online to the patients and that a large screen and projector is available in one of the communal rooms to facilitate this.

We noted that there was a lack of detail in patient files regarding their participation in activities whether the activity was being facilitated by the activity nurse or other nursing staff. We suggested that all activity offers should be recorded to ensure there is a clear picture of activity participation for each patient and look forward to seeing this at our next visit.

The physical environment

In general we found the unit to be dark and lacking a homely feel. The acoustics in the corridors in particular lead to noise carrying which we understand can be distressing for some patients. There is a lack of storage space in the unit especially when some patients may be admitted from broken down placements and will have a lot of belonging with them.

The design of the building has resulted in six large bedrooms with en-suite toilet and shower facilities, and six smaller bedrooms with en-suite toilet facilities but patients are required to access one of three showers available within the corridor. This imbalance does cause some issues among patients, although rooms are allocated on a needs led basis initially, then based on length of admission.

There are a number of communal lounge areas for use depending on patient choice and activities, one area is often used as a cinema room.

There is a well maintained enclosed garden space at the side of the unit which is well used by the patients.

The unit has only one bath that has been out of service since January 2021 and patients are missing being able to have a bath. We recommend managers follow up with estates service regarding acquiring a replacement bath.

Recommendation 2:

Managers should follow-up with estates services to ensure a replacement bath is acquired as soon as possible.

Any other comments

We heard that throughout the pandemic, staff have supported patient activity creatively on the ward and that the patients responded well to this. We were told that staff also worked hard to ensure families were kept up to date with patient care and that online meetings and visits with patients were facilitated where wanted. It was good to hear that all areas were provided with iPads to do this with patients.

We heard from patients that they are pleased that they are able to start getting back to outdoor activities and that they can once again have visits on the ward.

Summary of recommendations

1. Managers should urgently review the care plan documentation and ensure all nurses are aware of how to complete these appropriately.

2. Managers should follow-up with estates services to ensure a replacement bath is acquired as soon as possible.

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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