Mental Welfare Commission for Scotland

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

Date of visit: 6 June 2024

Where we visited

Cuthbertson Ward is a 20-bedded unit that provides assessment and treatment for older adults who have a diagnosis of dementia. The ward catchment area is northwest Glasgow; this includes parts of East and West Dunbartonshire and Glasgow City local authorities.

On the day of our visit, there were no vacant beds. Several people were boarded into the ward due to lack of bed availability in other catchment areas.

We last visited this service in August 2022 on an announced visit and made recommendations on risk assessments, care planning, life history information and power of attorney documentation.

The response we received from the service was that all of the recommendations had been actioned and there was a system of regular audit to monitor progress.

On the day of this visit, we wanted to follow up on the previous recommendations and look at communication with relatives, visiting arrangements and activity provision.

Who we met with

We met with, and reviewed the care of seven people. We also met with three relatives.

We spoke with the charge nurse, the patient activity co-coordinator and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

The relatives we spoke to were consistent in their positive view of staff and the care provided. One relative told us “Staff are fantastic, I always get in-depth, honest information”; “I feel we are working together to get the best outcome”. As a result of their confidence in staff and the care provided, one relative told us they felt able to go on holiday for the first time in many years.

We heard that staff were always very busy, but that they made time to speak to relatives. Relatives spoke of being invited to the multidisciplinary team (MDT) meeting shortly after admission and receiving phone calls from the consultant, or updates from staff when they visit.

Staff spoke of having supportive management who had increased the baseline staffing numbers as patient numbers increased to accommodate staff having ring-fenced time for contacting relatives, evaluating care plans or undertaking one-to-one sessions with their patients.

Of the individual in the ward that we spoke with, they told us that staff “do their job so well, they are very pleasant. If you need anything they help you.” We heard “the staff are great; they are good to me.”

Care, treatment, support and participation

Care records

Information on patient care and treatment was held in three ways; there was a paper file, the electronic record system EMIS and the electronic medication management system. Care plans and nursing reassessments were held in the paper system. MDT reviews and chronological notes were held on EMIS, along with risk assessments and Mental Health Act paperwork. The health board is in the process of transitioning across to a fully electronic system though no date has as yet been set for the completion of this.

We found Getting To Know Me forms in the patients’ files we reviewed. This document contains information on an individual’s needs, likes and dislikes, personal preferences and background, that enables staff to understand what is important to the individual and how best to provide person-centred care while they are in hospital. However, the level of information contained in them was inconsistent. The majority were not fully completed and lacked detail. As most patients will move on to further care placements, it is important that this information, along with more detailed life history information is recorded and goes with the individual through their care journey.

We reviewed the files of several patients who were prescribed, and receiving, as required medication for agitation, or where there were references to stress and distressed behaviours as part of the reason for admission. There were no care plans for the management of their stress and distress. For one person, a Newcastle model formulation was being developed. This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. Where an individual experiences stress and distress, we would expect to see a care plan outlining the

potential triggers, effective de-escalation strategies and threshold for use of as required medication for that individual.

The quality of the care plans we reviewed was inconsistent. The majority were lacking in person-centred focus and, whilst there were regular evaluations recorded, we found instances where this information had not been used to update the care plans to reflect the current presentation, care needs or legal status of the individual.

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 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.

Recommendation 2:
Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress that incorporates the information from their Newcastle formulation, where this exists. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation.

Recommendation 3:
Managers should review their audit processes to improve the quality of care plans to ensure these are consistently person-centred and updated to accurately reflect the patient's current needs and planned interventions.

Multidisciplinary team (MDT)

The unit has input from four consultant psychiatrists, one of whom is a locum, and 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 several nurse vacancies and is using bank staff to maintain staffing levels while posts are recruited to.

We heard that there has been a recent initiative to invite relatives to a MDT meeting early in their loved one's admission, and where they are unable to attend, proactive contact was made to ensure the relatives are involved and informed. There was evidence, both in the notes and from our discussions with relatives, that proxy decision makers and carers are attending meetings or are otherwise involved in these discussions.

We found the recording of MDT reviews inconsistent. While there was a clear record of the individual's presentation and progress, who was in attendance was not consistently recorded and the level of information in relation to decisions taken and actions required was variable.

We were told that there were four patients whose discharge was considered to be delayed, either as a result of delays in the granting of guardianships to authorise their placement or due to difficulties in finding a suitable placement. We heard that in the majority of cases, a

referral to social work was not made until the individual was considered ready for discharge, although the facility to make an earlier referral was available and could be utilised if it was felt necessary.

Recommendation 4:
Managers should audit MDT records to ensure these consistently record attendance, decisions taken and action plans.

Use of mental health and incapacity legislation

On the day of the visit, six people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). 20 people had section 47 certificates in place to authorise treatment under the Adults with Incapacity (Scotland) 2000 (the AWI Act).

Where patients in the ward were detained under the Mental Health Act, copies of detention paperwork were on file.

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. One individual was prescribed medication which was not included on their T3 certificate authorising treatment. This was brought to the attention of the consultant during our visit. One individual did not have a T3 on file. However, this had only become relevant on the previous day, and from the records, a DMP visit had been requested two weeks previously and the DMP second opinion visit to complete this had occurred earlier in the week.

Recommendation 5:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), this was recorded. We found copies of the powers held by the proxy in the majority of files we reviewed; where these were not on file, this was noted and a copy had been requested.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found completed section 47 certificates and treatment plans in the notes of all the patients we reviewed.

For patients who were receiving medication covertly, a covert medication pathway had been completed.

Rights and restrictions

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

During our last visit, there were significant visiting restrictions in place, with visitors being restricted to the dining and interview room, and visits at mealtimes were discouraged. We were pleased to find that the ward has now introduced person-centred visiting. Visits can take place in individual's bedrooms, as well as the interview rooms, the dining room and the ward gardens. Relatives are encouraged to support their loved ones at mealtimes if they wish, and there are no restrictions on visiting hours. We heard that while this was a big change in culture for the ward, it had been embraced by all staff and was working well.

We heard that advocacy was available and that referrals were made when an individual became subject to the Mental Health Act or was being considered for discharge under section 13zA of the Social Work (Scotland) Act 1968.

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

The ward had a dedicated patient activity coordinator who, along with the occupational therapy and physiotherapy staff, provided a range of small group activities, that included newspaper groups, football nights, movie nights, exercise sessions, reminiscence groups and sensory sessions, craft and gardening groups.

We heard that musical sessions were being provided weekly by the Common Wheel and other musicians were booked into the calendar on a regular basis as well as regular therapet sessions. Cognitive stimulation groups were run by the psychologist and occupational therapist. We heard that due to the level of need of those in the ward, there were a lot of one-to-one sessions, and these included pamper sessions, walks in the grounds and any other activity that the individual chose to participate in.

We saw evidence of activities being undertaken on a one-to-one and small group basis throughout our visit. The ward also has a 'magic table' activity centre; this has proved to be a valuable resource for both visitors and patients. We also heard that there is a dedicated budget to support outings and activity provision.

There was clearly a focus on activity provision in the ward and each individual had an activity care plan providing information on their preferred activities. However, the level of activity provision described and witnessed during the visit was not fully reflected in the chronological notes.

Recommendation 6:
Managers should ensure that activity participation and outcome is clearly recorded.

The physical environment

The ward is bright, spacious and in good decorative order. There were a number of quiet spaces as well as the larger sitting areas. There was dementia friendly signage throughout the ward and the artwork on the walls and windows that included pictures of old Glasgow that added interest to the environment.

The ward has two pleasant secure garden areas, directly accessible from the ward area. The gardening group, led by the patient activity co-ordinator has recently planted several containers of flowers and we heard that a gardener has recently volunteered their services to the ward once a week. The ward also has a dedicated activity room and a quieter room that housed an interactive table.

Summary of recommendations

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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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk