Mental Welfare Commission for Scotland

Report on unannounced visit to:

Iona House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 1 March 2024

Where we visited

Iona House provides 20 continuing care beds for older men and women with complex care needs from the west sector of the health board catchment area; this includes West Dunbartonshire, Bearsden and Milngavie, and Knightswood and Drumchapel.

On the day of our visit there were 16 people on the ward. We were informed that bed capacity is currently under review due to environmental and staffing issues.

We last visited this service in October 2022 as an announced visit and made recommendations regarding care plans and the locked door policy. The response we received from the service was that these issues had been addressed.

On the day of this visit, we wanted to follow up on the previous recommendations and to look at communication with families and proxy decision makers.

Who we met with

We met with, and reviewed the care of seven people, all of whom we met with in person. We also met with five visitors to the ward.

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

Commission visitors

Mary Hattie, nursing officer

Gemma McGuire, social work officer

What people told us and what we found

Care, treatment, support and participation

All the visitors we spoke with commented on staff being caring and considerate towards individuals and welcoming towards them when they visit: “staff are really good and attentive to my father”, “I know staffing is limited but nothing is a bother and they never complain when my dad needs anything or I ask to speak with them.” A number commented on how settled their relative/friend has been compared with other inpatient services, prior to moving to Iona Ward.

Relatives, several of whom were proxy decision makers, commented on good communication from nursing and medical staff. We were told that they were aware of when the multidisciplinary team (MDT) meetings were and were invited to attend. The ’open’ communication that staff offered helped to ensure relatives and carers could advocate for the rights of individuals. Those we spoke with on the day were clear they could raise anything with staff, knowing they would be listened to.

Staff advised us that the ward was significantly short of registered nurses due to vacancies and absences for a variety of reasons; bank staff were being used to ensure safe staffing levels, however we were told that because of this situation, staff struggled to meet timescales for care plan reassessments and other paperwork, and felt under considerable pressure.

Despite this, it was clear that staff remained very motivated to provide high quality care and knew the people in their care. When speaking to staff, they had a good understanding of individuals, having taken the time to get know their life stories, wishes, and preferences by spending time with them and listening to them.

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. Copies of power of attorney, guardianship certificates, as well as care plans were kept in the paper files. MDT reviews and chronological notes are held on EMIS along with Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) paperwork.

The health board is in the process of transitioning across to a fully electronic system and, as part of this, the ward is involved in a pilot programme developing electronic care plans, which will “go live” in around six weeks’ time. We were provided with a copy of the template and sample care plan which has been provided for staff guidance. This was very person-centred and clearly recorded the view of both the family and the individual. It is envisaged that having care plans on the EMIS system will make it easier to record evaluations and update care plans to reflect changes in care needs.

The care plans we reviewed were person-centred, although the level of detail they contained varied. We were told that there are regular reassessments and evaluations of care plans on a three-monthly basis. We found meaningful re-assessments in the files we reviewed, however the three-month target timescale was not consistently met. One person had been in the ward for a month, but their care plan had not yet been completed. On speaking to the charge nurse

and named nurse, we were advised that this was a work in progress which was due to be completed on the day of our visit.

Where individuals experienced stress and distress, there was a person-centred care plan for this, and a Newcastle formulation had been completed including clear advice on triggers and interventions. The Newcastle model is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge. Physical health care needs were also addressed within care plans.

In the files we reviewed, we found two do not attempt cardiopulmonary resuscitation (DNACPR) forms which did not record any consultation with the proxy decision maker. The Scottish Government produced a revised policy on DNACPR in 2016. This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

Recommendation 1:
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Multidisciplinary team (MDT)

The ward has regular input from psychiatry, psychology, occupational therapy, and pharmacy. Other allied health professionals are available on a referral basis. MDT meetings were scheduled weekly, and attended by the consultant psychiatrist, nursing staff and psychology. We saw evidence of relatives attending MDT reviews and proxy decision makers and family involvement was noted in discussions. We heard that the consultant provides telephone feedback for relatives who are unable to attend. MDT notes provided information on who attended, and a brief outline of decisions taken.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health Act. All documentation relating to the Mental Health Act was in place.

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 and corresponded to the medication being prescribed.

All patients were being treated under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

Where the individual had a power of attorney (POA) or was subject to a guardianship order, we found information advising of this and providing contact details for the proxy decision maker. Copies of the powers were available in all the files we reviewed.

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. Several of the s47 certificates we reviewed had not been completed to confirm the proxy had been consulted.

The Commission is working in partnership with NHS Education for Scotland to develop learning resources for the workforce to support and promote people's rights in the application of the AWI Act. Learning resources can be accessed here Adults with Incapacity Act | Mental Welfare Commission for Scotland (mwcscot.org.uk).

Recommendation 2:
Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted, and their consent sought; the manager must ensure that this process and outcome is clearly 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 was a locked door policy in place. The ward operates an open person-centred visiting policy. We found posters advising this as we entered the ward.

Information about the local advocacy service is available, however at the time of our visit no-one was making use of this service. We were advised by nursing staff that due to the level of cognitive and communication difficulties it was unlikely that the individuals currently in the ward would be able to engage with advocacy; however, curators are requested to maximise rights in legal proceedings at Mental Health Tribunals.

Two individuals were on continuous interventions for all or part of each day, due to their level of distress. Staff were very clear about the rationale for this and were able to describe the strategies they used to alleviate this and reduce risk in the least restrictive way possible.

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 has regular input from occupational therapy staff who attend at least once each week. There was information about music sessions and other activities available around the ward. However, the ward does not have a dedicated activity co-ordinator post. We heard from staff that due to the high levels of clinical activity, they were unable to provide a regular programme of activities. We were told that they do undertake individual and small group activities on an ad-hoc basis, as and when time allows. This was confirmed in our conversations with relatives and from the chronological notes. We were told that the health care assistants provide a lot of one-on-one activities which go unrecorded, and work is

underway to give all band 3 health care assistants access to EMIS and training in using this, to enable them to record activities in the notes. We feel that the ward would benefit from the provision of a therapeutic activity nurse post who would provide opportunities to increase the range and frequency of activities provided and ensure there is a focus on activity provision on a more structured basis.

Recommendation 3:
Management should ensure that activity provision is prioritised, so individuals have access to a range of therapeutic and social activities on a daily basis, to meet their needs and preferences. This should include progressing the provision of a dedicated activities co-ordinator post to facilitate this.

The physical environment

The layout of the ward consists of a large dining room, a sitting room, a smaller quiet lounge, a small interview room near the ward entrance, five single bedrooms with an en-suite toilet but no shower, and three dormitories which can accommodate up to five beds each. There is an ensuite toilet and shower in each dormitory, and one bathroom off the main corridor. There is a small pleasant secure garden area with a gazebo and garden furniture.

Staff highlighted that the current configuration requires people in single rooms to access the showers in the dormitories, which impacts on the privacy of others, and that three showers for 16 people, many of whom require considerable support with personal care and find it distressing, is not really adequate.

We were told that the accommodation is being reviewed as part of the older adults' mental health service review, which is due to report later this year. We look forward to hearing how the review has progressed when we next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Recommendation 2:
Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted, and their consent sought; the manager must ensure that this process and outcome is clearly recorded.

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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.

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