Mental Welfare Commission for Scotland

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

Date of visit: 19 April 2018

Where we visited

Claythorn House is a 12-bedded unit providing assessment and treatment for adults who have a diagnosis of learning disability, mental illness and behavioural difficulties. There are currently 11 patients being treated within the unit, with two rooms having been reconfigured to accommodate the particular needs of a patient.

The service is part of the overall Specialist Learning Disability Inpatient provision for the NHS Greater Glasgow and Clyde area, provided across two sites, Claythorn House and Blythswood House.

We last visited this service on 12 March 2017 and made recommendations about auditing patient files, ensuring patients get feedback in relation to issues raised about the service and recording activities to ensure the service can audit patient participation or cancellation of activities.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at ongoing issues in relation to the delayed discharge of patients who have been assessed as ready to move on from hospital. This is because we heard on our last visit about significant delays for some patients. We also heard how this impacts on the service being able to achieve timely admission for adults in the community who require a period of inpatient assessment and treatment.

Who we met with

We met with four patients and reviewed the care and treatment of six patients, one of whom was supported by an advocate. We did not meet with any relatives or carers on the day of the visit.

We spoke with the service manager, the senior charge nurse, the charge nurse and the activity coordinator

Commission visitors

Yvonne Bennett, Social Work Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The patients we met during the visit all spoke very positively about the care and treatment they received within the unit. They told us that they found staff to be very helpful and caring, and that they could go to staff for help with anything they were worried about. One patient explained how the staff helped her to prepare for attending reviews about her care, and how this involved writing down positives and

negatives so that she remembered to say everything she wanted to say during these important meetings.

It was evident from the nursing care plans that staff knew patients well and their care plans were detailed and person centred, using this knowledge to ensure patients' care met their individual needs. We saw the dates these care plans were reviewed but felt that this review process might be enhanced by more of a summary and evaluation of progress since the last review in a narrative form, rather than simply stating that care plans had been reviewed and required no change.

The multidisciplinary meetings (MDTs) were well documented and evidenced the involvement of the full range of disciplines in individual patients' care, and included patients and families/carers according to personal preference.

Functional assessments by occupational therapy (OT) and speech and language therapy (SALT) also informed patient care and treatment on an ongoing basis.

Within the files we saw good attention to physical health care, with the use of the 21st century health care checks by a lead nurse on admission. This is a tool specifically designed for adults with learning disability, whose patterns of health needs are higher, and different from those of the general population, and are often unmet. In addition we heard that there are three general practitioner sessions within the ward weekly and referrals to specialist physical health services as required.

We were pleased to see evidence throughout case recording of patient involvement and a variety of different methods to ensure this was meaningful and tailored to the individual's ability to contribute.

Overall, however, the case files were very large and contained a range of historical and outdated material, which made them difficult to navigate and find pertinent key information. This is partly due to the length of admission and, in some cases, delays in discharge. We saw a working example of small passport documents, which staff have been developing to capture key information and interventions for a patient. We thought these would be useful tools, but that they required some further refinement. We look forward to seeing how these develop.

In the meantime, an audit of case files should be carried out to ensure relevant and current key information is readily accessible.

Recommendation 1:

Managers should carry out an audit of patient case files to ensure information they contain continues to be current, relevant and reviewed.

Use of mental health and incapacity legislation

On the day of our visit eight patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 and all legal documentation in relation to this was up to date.

Certificates authorising treatment (T2/T3/T4) were in place, authorising the prescription and administration of medication routinely and in response to urgent need for treatment.

A number of the patients were also subject to welfare guardianship under the Adults with Incapacity (Scotland) Act 2000 (AWI) and, for some, we saw copies of these orders and details of the powers they conferred on the guardian. Orders were not present in all files which referred to the existence of a guardian. We felt it was important that they are available so staff knew who the guardian was, what powers had been granted within the order and which of these powers were delegated to nursing staff on a day-to-day basis.

Certificates and treatment plans authorising physical treatment were in all of the files we reviewed.

Recommendation 2:

Managers should ensure that copies of guardianship powers are included in individual case files to confirm the existence of a proxy decision maker and associated powers for the patient.

Rights and restrictions

Claythorn House operates a locked door policy in recognition of the high levels of vulnerability of the patients within the service. In addition there are comprehensive risk assessment and management plans in place for individual patients, which detail arrangements for time out of the ward.

Four patients were on enhanced observations and we saw evidence of the rationale for this additional support, and regular reviews of the continued need for this level of observation.

A number of patients required restraint as part of their care and treatment and, where this did happen, we saw a robust process of how this was recorded, audited, analysed and reviewed within the operational management team, the MDT and the Violence Reduction team.

Activity and occupation

One of the recommendations from the last visit was that the service should ensure a weekly programme of activities was in place and that participation in activities was recorded. We met with the activity nurse during the visit and heard how activities are

planned on an individual basis, recognising personal interests and choice, but also tailored to the patient's stage in the recovery process. For some patients this was a minimal programme which was reviewed and adapted as recovery progressed, while for others it was in relation to learning or refining skills to support discharge back to the community. In addition, there were opportunities to engage in recreational activities and planning of special events e.g. Burns' Night and St. Patrick's Day, and patients showed us photos of these events, which they had clearly enjoyed.

There were clear records of patient participation in activities, albeit held across the patient file or in electronic format. This was an improvement from the last visit, but could further benefit from having one single means of recording to ensure a comprehensive overview of patient participation.

The patients we spoke to reported that they had opportunities to engage in a range of activities both within and out with the ward, and enjoyed taking part in these activities.

The physical environment

The ward environment was bright, well maintained and welcoming. Patients had access to a large sitting room/dining room as well as a multi-purpose room and training kitchen. There was also a smaller lounge area which could be used as a quieter space and which patients advised they could use as a cinema by projecting films onto a big screen, which was a popular activity for many of the patients.

The bedrooms were a good size and could be personalised with photos and personal belongings.

We heard that the ward can be noisy at times, but that efforts are made to ensure this is addressed as much as possible, by spreading activities across rooms and by accompanying patients out with the ward wherever possible.

Patients had access to a small garden which was well kept and inviting. The only issue raised in relation to the garden area was that it is small and cannot comfortably accommodate all of the patients. We heard that options are being investigated for an additional garden space and this would offer choice and space for patients who may have very diverse needs.

Any other comments

There were six patients whose discharge was delayed, with the longest delay from 2016. We were advised of a range of reporting and monitoring arrangements which are in place at senior management levels, but felt that this should also be recorded for each individual patient, so that the focus on discharge remains person centred and current. While we heard of progress for some patients, there were others for whom there were no plans in place and we were very concerned about what this

means for the individual. We will follow this up with the relevant Health and Social Care Partnerships.

The service is currently undergoing a process of redesign supported by the National Development Team for Inclusion. This process is in its early stages and we will be interested to see how this develops to ensure the service remains able to respond to changing and evolving need.

Recommendation 3:

Managers should ensure that the monitoring of discharge planning activity for patients whose discharge has been delayed is clearly documented in care plans so this remains focussed and within agreed timescales.

Summary of recommendations

1. Managers should carry out an audit of patient case files to ensure information they contain continues to be current, relevant and reviewed.

2. Managers should ensure that copies of guardianship powers are included in individual case files to confirm the existence of a proxy decision maker and associated powers for the patient.

3. Managers should ensure they monitor and record discharge planning activity for patients whose discharge has been delayed so this remains focussed and within agreed timescales.

Good Practice

During the visit, we observed how staff were required to manage the care and treatment of a diverse and complex range of patients' needs. Throughout the day we observed the whole team intervening in ways which were supportive, therapeutic and nurturing and came from an excellent knowledge of individual patients.

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.

Mike Diamond
Executive Director (Social Work)

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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