Mental Welfare Commission for Scotland

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

Date of visit: 19 March 2018

Where we visited

Iona ward provides 20 continuing care beds for older men and women. We last visited this service on 5 June 2014 and made recommendations about the facilities, repairs and communication with relatives.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at activity provision and care planning.

Who we met with

We met with and/or reviewed the care and treatment of nine patients.

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

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

Fionnuala Williams, Temporary Medical Officer

What people told us and what we found

Care, treatment, support and participation

The ward benefits from daily general practitioner (GP) cover and there is evidence of good physical health care being provided in response to changes in patients' conditions. We are advised that the GP does undertake annual physical health checks, but could not find evidence of this within the care file.

The ward has input from a range of allied health professionals, including regular sessions from occupational therapy (OT) and physiotherapy. Psychology, speech and language therapy, pharmacy and dietetics are all available on a referral basis.

Multidisciplinary team meetings are held weekly and there is a record of who is in attendance and of decisions made; requirement for NHS continuing care is actively reviewed.

The care plans we reviewed contained person-centred information and were regularly reviewed. However, the care plans for management of stress and distress did lack detail about triggers and effective strategies for management. There was evidence in the chronological notes that stress and distress was being managed in a person-centred way, but this had not been formalised in the care plan.

There were other aspects of care being provided at an enhanced level, to that set out in care plans, such as patients being provided with a higher level of personal care than the care plan reflected, or additional input to ensure medication compliance. Where

there were proxy decision makers or relatives in contact, there was evidence they were included in discussions around care decisions.

Several of the care files we reviewed included Do Not Attempt Cardiopulmonary Resuscitation forms, these evidenced consultation with proxies or relatives and were reviewed regularly.

Life histories varied, with some patients having detailed life story books or photo albums which were used as a base for reminiscence work, whilst for others there was no life history recorded. Information about the patient's past life, interests and preferences are an important part of the assessment process and inform care planning. We were advised that several of the patients had been in hospital or a care home for many years before being transferred to Iona ward and had no close family contacts, therefore it was difficult to obtain information at this point in their journey.

Recommendation 1:

Managers should ensure that life histories are compiled as early as possible in the patients' journey and incorporated into the care file.

Use of mental health and incapacity legislation

There was one patient on a compulsory treatment order. All detention paperwork required under the Mental Health (Care and Treatment) (Scotland) Act 2003, was in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 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.

All patients we reviewed had been assessed as lacking capacity in relation to decisions about medical treatment and there were s47 certificates in place with treatment plans.

Where there were proxy decision makers in place, this was recorded in care files, and copies of the powers were held separately. The powers were not recorded in the care files.

Recommendation 2:

Managers should ensure that a copy of the powers held by proxy decision makers are available within the care file.

Rights and restrictions

The ward door is locked due to the vulnerability of the patient group. Entry and exit is controlled by nursing staff and we did not see any patients wanting to leave the ward during our visit.

Activity and occupation

We were advised that there is OT input three times a week, and there were excellent OT assessments and evidence of therapeutic input on file for some patients. There is a regular weekly music group. There was previously regular therapet visits which we were told were well received by patients, but this is currently unavailable due to illness. There is no dedicated activity co-ordinator and no formal activity programme. Nurses provide activities on an ad-hoc basis when they have time available, this is mostly later in the day due to the clinical workload and the complex care requirements of their patient group. There was limited evidence of activity provision within the notes we looked at.

Recommendation 3:

Managers should consider the provision of a dedicated staffing resource for activities and ensure that each patient has access to a programme of activities to meet their individual needs and interests.

The physical environment

The ward was clean and bright and had a pleasant calm atmosphere but there was limited personalisation of bed areas. During our visit we noticed that there were several curtains partially off their rails. We were advised by the senior charge nurse that repairs are carried out promptly when required. Curtains are pulled of their rails on a regular basis by patients, but this is attended to every week.

We had previously made comment regarding the adequacy of showering and bathing facilities. There are shower rooms attached to each dormitory area, and a large, well-equipped bathroom.

There is a small secure garden area accessible from the corridor. We were advised by the senior charge nurse that there is funding available to landscape this area to make it more appealing, and managers are securing a contractor to undertake the work.

There are separate dining and sitting areas, and a quiet sitting room which is equipped with several pieces of multisensory equipment. However, due to lack of storage space, this area is also being used for storage of excess beds.

Recommendation 4:

Managers should provide appropriate storage space so that excess equipment is not stored within patient areas.

Any other comments

The current patient group covers a wide spectrum of need. This includes those who are mobile and can be distressed, alongside very frail patients who are receiving end of life care. Meeting such a wide spectrum of need within the one area does present challenges for the nursing team.

Summary of recommendations

1. Managers should ensure that life histories are compiled as early as possible in the patients' journey and incorporated into the care file.

2. Managers should ensure that a copy of the powers held by proxy decision makers are available within the care file.

3. Managers should consider the provision of a dedicated staffing resource for activities and ensure that each patient has access to a programme of activities to meet their individual needs and interests.

4. Managers should provide appropriate storage space so that excess equipment is not stored within patient areas.

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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