Mental Welfare Commission for Scotland

Report on announced visit to: Iona Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

Date of visit: 12 March 2020

Where we visited

Iona Ward provides 20 continuing care beds for older men and women with complex care needs. On the day of our visit 14 beds were occupied. We last visited this service on 18 March 2018 and made recommendations in relation to life history and activities, proxy decision makers and the physical environment. We heard that since our last visit there has been a change in the patient population. Previously the ward was providing palliative care for a number of patients who were very physically frail. The current patient population is more physically fit, but have complex mental health needs.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and also look at the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Who we met with

We met with and reviewed the care and treatment of seven patients and met with three relatives.

We spoke with the senior charge nurse, charge nurse, and one of the consultant psychiatrists attached to the ward.

Commission visitors

Mary Hattie, Nursing Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The ward has input from two consultant psychiatrists. GP cover is provided Monday to Friday. Outside these hours medical cover is provided by the duty doctor rota.
Multidisciplinary team (MDT) meetings are scheduled weekly, and are attended by the consultant psychiatrist and nursing staff. Psychology, pharmacy, physiotherapy and other allied health professionals are available on a referral basis and we were told there is a prompt response to referrals. MDT reviews were well documented, with clear actions and outcomes.

Patient's notes are currently recorded in two separate formats. Egton Medical Information Systems (EMIS) records chronological and MDT documentation electronically, with all other notes held on paper file. We were told EMIS will in the future be able to accommodate all information relating to patient's care and treatment.

We made a recommendation previously in relation to recording life history information as this is essential to the development of person-centred care plans and the delivery of person centred care. We found 'Getting to Know Me' forms in all the files we reviewed, which contained varying levels of detail. This is a document which records a person's needs, likes and dislikes and background, and is aimed at helping hospital staff understand the person and how best to provide person-centred care. The information these contained had been used in the development of person-centred care plans. We were advised by the senior charge nurse that a number of relatives have expressed understandable irritation at having to keep retelling their relatives' story every time they are moved between hospital wards or care homes and that the service is looking at ways of ensuring this information is captured early in the patients' journey and transfers with them. Risk assessments were regularly reviewed and updated.

Care plans were reviewed regularly. Reviews contained information on progress or changes in patients' needs and treatment. However this was not reflected in the care plan itself, which was not updated to include this new information and reflect the care being delivered.

We found that the quality of care plans for the management of stress and distress varied significantly. There were some excellent person centred care plans based on the Newcastle model which contained information on the individuals' triggers and effective distraction and de-escalation techniques. Others were more generic and did not contain adequate information about person centred interventions.

We found evidence of involvement of proxy decision makers and families in care plans and decisions about future placement. We are advised that relative involvement and support is provided on an ongoing basis and that discussions with families around ceilings of care are being implemented.

Where there is no guardian or attorney for a person who cannot consent to a decision about cardio pulmonary resuscitation (CPR), it is a requirement to consult with the close family, as well as trying to establish the wishes of the patient. In all cases, this involvement or

consultation should be recorded. In all the care files we reviewed which contained 'Do not attempt CPR' forms which had been completed on the ward, there was evidence of discussion with nearest relative or proxy as appropriate.

The relatives that we spoke with were very positive and complimentary about the care their loved ones received. They told us that they were impressed with the warm friendly approach of ward staff and the cleanliness of the environment. We heard that care and communication was excellent, and the nurses were caring and approachable.

The atmosphere in the ward was calm. Patients seemed comfortable in the company of staff. We saw that staff were proactive in engaging with patients. All the interactions we saw were warm, friendly and respectful.

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

Recommendation 1:

Managers should audit care plans to ensure they are person centred and updated following reviews to reflect the relevant changes to patients' presentation and care needs.

Use of mental health and incapacity legislation

Four of the patients we saw were subject to detention under the Mental Health Act. We found all of the relevant paperwork in the care files and on the electronic system. We also saw that certificates authorising treatment (T3) were in place, and that, prescribed medication was authorised appropriately.

Where an individual lacks capacity in relation to decisions about medical treatment, this is provided under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). A certificate 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 AWI Act. During this visit all the patients we reviewed lacked capacity. Section 47 certificates and treatment plans were in place and proxy decision makers or relatives had been consulted appropriately. Where patients were being given medication covertly covert medication pathways were in place.

Where individuals had granted a power of attorney, this document and their contact details were recorded in the care plan, but copies of the powers granted were not available. We made a recommendation in relation to this on our previous visit.

Recommendation 2:

Managers should have a system of audit in place to 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. Visitors wishing to enter or leave the ward were attended to promptly by nursing staff. We did not see any patients wishing to leave the ward during our visit.

Information about the local advocacy service is available in the ward and we are advised that they respond positively to referrals, however at the time of our visit no-one was making use of this service.

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

We were advised that there is regular occupational therapy input into the ward several days each week. Whilst there is no dedicated activity co-ordinator there is an activity programme which includes activities provided by both occupational therapy and nursing staff and outside volunteers. This includes pet therapy, music groups, reminiscence, pamper sessions, and card and domino sessions. We saw volunteers spending time chatting with patients and doing their nails and throughout our visit nursing staff were engaged with patients either in activities or simply chatting with them. We found that some individuals had person-centred activity plans informed by their previous hobbies and preferences. However, recording of activities in the chronological notes was limited.

Recommendation 3:

Managers should ensure that activity provision is recorded within patient notes.

The physical environment

The ward has a large bright dining area and a homely lounge as well as a quiet sitting area with multisensory equipment. Sleeping accommodation is a mixture of single rooms and small dormitories. There is access to a small secure garden area, and the wider grounds of Gartnavel Royal Hospital. The ward is clean, bright and well maintained. The atmosphere on the ward was calm, welcoming and friendly. On our previous visit we made a recommendation in relation to storage of equipment in patient areas. This has been addressed. All patient areas were clean and free from clutter.

Summary of recommendations

1. Managers should audit care plans to ensure they are person centred and updated following reviews to reflect the relevant changes to patients' presentation and care needs.

2. Managers should have a system of audit in place to ensure that a copy of the powers held by proxy decision makers are available within the care file.

3. Managers should ensure that activity provision is recorded within patient notes.

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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