Mental Welfare Commission for Scotland

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

Date of visit: 12 November 2020

Where we visited

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. From August 2020 the Commission undertook a phased return to our visit programme following recommendations in the Scottish Government's roadmap to recovery.
We were keen to visit Kelvin House at Gartnavel Royal Hospital as it had been some time since our last local visit and we had received some correspondence from patients and relatives.

This local visit was undertaken using a combination of telephone interviews and in person interviews on site at Kelvin House.

Kelvin House is a 12-bedded rehabilitation unit providing care and treatment for adults with severe and enduring mental health problems. The rehabilitation service in Gartnavel Royal Hospital consists of two wards, Kelvin House and Clyde House. The function and configuration of these two wards was revised in 2017.

There is a weekly referral meeting where consideration is given to suitability for either ward. The patients in Kelvin House generally need a shorter period of rehabilitation than those in Clyde House. However, the length of rehabilitation is likely to be between six months and several years due to the complexity of the patients' mental health and behavior difficulties. Patients can often be acutely unwell due to a relapse in their mental health. Patients' motivation and engagement can be poor due to the chronic nature of their illness. There is a monthly service improvement meeting which is attended by all disciplines within the multidisciplinary team (MDT). This meeting is used to identify, discuss and review any service improvements or innovations.

On the day of our visit there were 12 patients, including one of whom had just recently moved from there from Clyde House.

We last conducted a local visit to Kelvin House in January 2017. At that time we were positive about the care and treatment people were receiving. We also visited Kelvin House as part of our themed rehabilitation in mental health visit schedule in 2018.

Following our 2017 visit we made recommendations relating to care planning, life history information and the physical environment.

On the day of this visit we wanted to follow up on the previous recommendations and also find out how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and on the mental health of patients. We also wanted to to give patients an opportunity to raise any issues with us and to ensure the care and treatment and the facilities are meeting patients' needs.

We also looked at:

- Care and treatment and service user participation
- Therapeutic activity and occupation
- Use of legislation
- Physical environment

Who we met with

We met directly with two patients, reviewed the care and treatment of seven, and spoke with one set of relatives.

We spoke with the Senior Charge Nurse (SCN), the two ward based charge nurses, the rehabilitation liaison charge nurse, a staff nurse and a student nurse.

Commission visitors

Lesley Paterson, Nursing Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

We heard from staff and patients that care has continued very much as normal throughout the Covid-19 pandemic with patients continuing to have good access to their psychiatrists and input from the wider multidisciplinary team and advocacy services. We were pleased to hear that although subject to some ongoing restrictions, most patients have generally coped well with the experience of the ongoing pandemic and understand the need for the restrictions and change in practices.

Care, treatment, support and participation

The patients and relatives we spoke to were generally very positive about the care and treatment provided by the clinical team. We heard a concern regarding engagement in ensuring patients were motivated to attend to their activities of daily living and their care and treatment programs

There is a diverse group of patients in the ward. Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their ability to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. We did however see evidence of considerable efforts by nursing, occupational therapy (OT) and psychology staff to encourage engagement in both their treatment and activities.

Kelvin House is served by two part time Consultant Psychiatrists who both hold weekly MDT meetings, a part time clinical psychologist and OT staff. Referrals are made to physiotherapy, dietetics, podiatry or speech and language therapy if this input is required and patients are supported to attend all national screening initiatives as required. There is a visiting GP service, and all annual health checks are carried out along with any other required monitoring including bloods for Clozapine therapy, high dose antipsychotic monitoring, and diabetic monitoring. Although pharmacy staff do not currently routinely attend the MDT meetings, they are available for consultation, completion of medication reviews, and will spend time with patients discussing their medication if this is required.

Patients are invited to attend the MDT meeting but some choose not to and instead will liaise with their consultant psychiatrist and nursing staff prior to the meeting to ensure their views are conveyed and then receive post meeting feedback afterwards. When appropriate, relatives are invited to attend MDT meetings via video conferencing. All patients in Kelvin House are managed on the Care Programme Approach (CPA) and most attend their meetings. Weekly community meetings take place and these allow for patients to discuss any ward based issues, concerns or views they may have. The patients report that these meetings are useful, supportive and they feel their views are listened. MDT meetings were clearly recorded and it was clear to see who attended and what the meeting outcomes / actions were. There was evidence of regular risk assessment and risk management contained within the records.

Patient records are stored in a combination of electronic notes (EMIS) and paper notes. It was clear from reading the records that staff knew the patients very well and care and treatment appeared to be individualised and appropriate to the current needs. We had previously recommended that life story work was completed for each patient and were pleased to see that there has been good progress in this area. We were told that this work is always offered and promoted, but some patients choose not to participate in this for a variety of reasons.

Some of the initial nursing assessments were excellent and very comprehensive. Care plans were person-centred and very detailed in terms of physical health, mental health, and social needs. However, some had no review date identified and others appeared to not have been reviewed for some time. Although we felt there was an overall improvement in the care plans, we felt they could better evidence patient involved in their compilation and there was little evidence of the patient's narrative. Even if a patient chose not to participate, this is also important to record.

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

Although feedback from this visit was positive, some individual concerns regarding care and treatment were raised with us. We explored these with senior nursing staff on the day and feedback was given following the visit.

It was evident from the chronological notes, and from talking to nursing staff, that they actively promote and support family involvement in the patient's life and, where appropriate, in discussion of the patient's care and treatment. Prior to the Covid-19 pandemic, informal work with carers was taking place and there were considerations into starting a formal Carers Group. The logistics of this in the current climate are still under consideration but other ways to engage with carers are being explored.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. Kelvin House staff have prioritised family contact, and patients have been able to maintain telephone or video call contact where appropriate. There is a very useful good checklist in each patient's file to prompt monthly discussion between the named nurse and the patient on advanced statements, advocacy, named person, and consent to information sharing. We were told on the day by both patients and staff that advocacy input to the ward is very good and there is a good uptake.

Recommendation 1:

Managers should ensure there is consistency in the quality of the care plans, that they better evidence patient involvement and are regularly reviewed.

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

Therapeutic activity and occupation

There is a full-time and a part-time psychologist who covers both Kelvin House and Clyde House and delivers a number of evidence-based therapies. These include cognitive behavior therapy

(CBT) for people with psychosis, cognitive remedial therapy (CRT) and behaviour family therapy (BFT). A number of nursing staff are trained in BFT and CRT and also deliver these therapies. The psychologists create formulations and mini formulations on distressed behaviors to maximise the options for patients on discharge.

Every file we reviewed contained comprehensive OT functional assessments, reviews, structured activity planner, weekly activity programmes, and OT care and treatment plans. There is a full-time OT and a full time OT technical instructor covering Kelvin House and Clyde House, and at least one of them is in the ward every day, carrying out both group and individual work.

Nursing staff also contribute to the running of the weekly activity programme and, as far as possible, there is a rehab activity nurse identified on every shift, although there is no distinct funding for this. There are a range of activities taking place on the ward including soup groups, walking groups, art groups, socialising through games, weekly themed nights, and regular cooking sessions. Attendance at community resources such as The Common Wheel, The Coach House, Flourish House is currently suspended. However we were pleased to see that there have been many alternative ward-based projects taking place, including restoring the garden furniture.

Patients usually self-cater at least twice a week and would normally shop for this themselves. However, during the pandemic, staff have been carrying out the shopping. Patients do their own laundry, change their beds, and keep their rooms tidy and clean. Nursing staff compile weekly planners with each patient. There is an effort to fully involve the patient in these planners in order to empower them and hopefully maximise engagement. An activity board with the week's events in the ward was clearly displayed in the corridor.

Use of mental health and incapacity legislation

Eight out of the 12 patients currently in Kelvin House are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, one is detained under the Criminal Procedure (Scotland) Act 1995, and three are informal. We were pleased to see that all legal documentation was well maintained within the patient files and we did not find any issues with regard to T2 and T3 forms which authorise prescribed psychotropic medication. Additionally section 47 certificates and treatment plans under the Adults with Incapacity (Scotland) Act 2000 ('The AWI Act') were in place where required.

Personal spending plans for those patients whose funds are managed under Part 4 of the AWI Act were thorough, and there were efforts to encourage spending on appropriate items and encourage patients to consider creative ways to spend their money.

The physical environment

The accommodation is comprised of single bedrooms, some with en-suite shower and toilet facilities. The ward benefits from a number of communal areas including a spacious sitting / dining room, several smaller sitting areas and a private garden space. We had previously made a recommendation that the garden space be cleaned and free from litter, and were pleased to see it is much better maintained.

We noticed that high traffic areas are looking a little tired. However, the ward environment remains clean, tidy and free from any unpleasant odours. There is a fully equipped therapy kitchen available however staff told us it is almost impossible to use in the warmer weather, due to a lack of any active airflow or ventilation rendering it far too hot and uncomfortable, especially when using the oven. This is unfortunate and patients desist from using it for this reason.

Gym equipment is available as is access to a computer which helps patients to order online shopping. This has been hugely beneficial in light of Covid-19 restrictions. The treatment room, which is effectively just a cupboard, remains a cause of frustration for the team as it is too small, cramped and not fit for purpose. It can barely accommodates a nurse and a patient and could present safety issues if a patient became distressed.

We made a previous recommendation that the service manager should review the adequacy and safety of the treatment room and were dismayed to see there has been no change. Patients requiring any physical interventions including intramuscular medication administered, phlebotomy, ECG procedures, or any physical examination carried out are required to have this performed at their bed space. This is not acceptable in light of infection control, privacy, dignity and respect for boundaries.

Recommendation 2:
Managers should review the adequacy, safety and effectiveness of the ventilation within the therapy kitchen.

Recommendation 3:
Managers should review the adequacy and safety of the treatment room and the current need to perform all physical health procedures in the patient's bed.

Any other comments

We were informed by nursing staff that there is a lack of social work input into the ward, meaning it is difficult to secure funding for suitable accommodation and support packages. This can lead to delays and place barriers to sustainable discharge. We were informed there were five patients identified as ready for discharge; however, the lack of suitable accommodation was causing a delay. These cases will be followed up on an individual basis.

Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment, creativity, and finding new ways of working. We were impressed with the way in which this service has adapted and it is hoped the positive changes that have benefitted some aspects of patient care can be continued and developed in future models of care.

Summary of recommendations

1. Managers should ensure there is consistency in the quality of the care plans, that they better evidence patient involvement and are regularly reviewed.

2. Managers should review the adequacy, safety and effectiveness of the ventilation within the therapy kitchen.

3. Managers should review the adequacy and safety of the treatment room and the current need to perform all physical health procedures in the patient's bed.

Good practice

We noted the efforts of the SCN to ensure all staff had professional input to enhance the care and treatment they provide, such as training in psychosocial inventions, physical healthcare, and autistic spectrum disorder. Additionally, nursing staff are given areas of interests on which they lead on. For example: lead mentor, physical healthcare champion, patient's rights champion. We feel this is positive and not only focuses on each staff member's strengths and areas of interest, but fosters a sense of ownership and develops specialist knowledge which can be promoted and shared within the team.

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.

Alison Thomson
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 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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