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: 21 November 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

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 reviewed in 2017 and has largely remained unchanged since that time.

On the day of our visit there were eight patients in the ward, two of whom were female and the rest where male. The management acknowledged that there had been recent issues with a lack of referrals to the service due to staffing issues at the referring hospitals. Despite this the ward staff have been deployed to provide outreach to support patients in the community to meet their rehabilitation goals.

We last conducted a local visit to Kelvin House in November 2020, we made recommendations for improvements in the quality and reviews of nursing care plans, the ventilation system in the kitchen and the adequacy of the treatment room.

On the day of this visit we wanted to follow up on the previous recommendations and also find out how the service was managing in their recovery planning since the Covid-19 pandemic. We also wanted 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.

Who we met with

We met with and reviewed the care and treatment of five patients, and spoke to the family of one patient.

This local visit was undertaken using a combination of virtual meetings with management prior to the visit and face-to-face contacts on the day. We spoke to the senior charge nurse (SCN), the occupation therapist (OT), members of the nursing staff and one of the local activity coordinators for the ward.

Commission visitors

Justin McNicholl, social work officer

Mary Leroy, nursing office

What people told us and what we found

The current management team for the service are updating the operational policy for the rehabilitation service through their internal system improvement team, which incorporates a range of disciplines in the rehabilitation service.

The majority of admissions to the ward come from Gartnavel Royal Hospital and Stobhill Hospital. Kelvin House is considered to have shorter periods of rehabilitation than those in Clyde House. The length of rehabilitation is likely to be between six months and several years due to the complexity of the patients' mental health and behaviour difficulties. The longest stay for any patient on the ward during this visit was two years. Patients admitted to the ward can often be acutely unwell due to a relapse in their mental health. Patients' motivation and engagement can be variable due to the chronic nature of their illness. The service hold monthly service improvement meetings which are attended by all disciplines within the multidisciplinary team (MDT). These meetings are used to identify, discuss and review any service improvements or innovations.

As our visit was announced, patients, relatives, and staff were prepared for our visit and we were given full access to the ward to meet with patients and staff. All patients we spoke with were satisfied with the nursing and allied health professionals' care and support provided.

It was clear that rehabilitation and recovery was at the heart of the care being delivered to patients with a wide variety of opportunities open to all. Patients were able to describe being involved in their treatment and rehabilitation.

On meeting with staff and patients, there was a clear view expressed that care has continued consistently since our last visit, with no barriers noted around access to psychiatrists, or to the multidisciplinary team or advocacy services. Despite a number of patients testing positive for Covid-19 in the last month, we heard from the patients that this had little or no effect on their rehabilitation programme.

Care, treatment, support and participation

The patients we met with during our visit spoke positively about their care and treatment on the ward. Staff were described as "great", and as "caring and supportive" when aiding patients with their recovery. There was evidence that patients were consistently provided one-to-one sessions with staff, to review their progress and to plan for the days and weeks ahead. Patients were aware that they could speak to their doctor if they wished to and could attend weekly meetings. Patients talked extensively about the variety of activities that they could participated in that included playing pool, making meals, social outings, walks with staff to the local shops, and undertaking exercise.

We heard from managers that there had been no significant issues with staffing, although at times, bank staff are required to meet the needs of the patient group. Staff that we spoke with appeared to take pride in their work and spoke positively about working in Kelvin House as it helps them to "make a difference to patients" and told us that "our role in the community discharge planning is very rewarding".

Care Plans

Care plans describe the detailed interventions to be undertaken that then ensures consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being. During our last visit we noted that some care plans had not been reviewed for some time and as a result of this, we took time to review this area. Positively, we saw a range of detailed and person-centred care plans that addressed both physical and mental health care needs. The care plans identified needs, they outlined interventions and agreed goals to meet needs, which included discharge planning.

There was evidence of patient participation and reasons, where appropriate, for this did not happen. Each patient had a risk assessment on file, which again was comprehensive and showed evidence of appropriate interventions and strategies to manage risk. Care plans and risk assessments were regularly reviewed, with evidence that a patient's progress was evaluated and considered. Overall we were impressed with the quality of both care plans and risk assessments.

We found good evidence that all physical health care was being delivered and available, with patients having good access to the local General Practitioner at Anniesland Medical practice. This ensured that annual health checks were carried out, along with any other required monitoring of bloods for Clozapine therapy, high dose antipsychotic monitoring, and diabetes.

On the day of our visit we were told that no patients whose discharge from hospital was delayed.

Multidisciplinary team (MDT)

While we heard that there were vacancies in psychology posts, which is a service-wide issue, we heard from patients about their positive experience of having face-to-face psychological input. The senior staff that we spoke with advised us of the availability of behaviour family therapy (BFT) to support patients and their families on their recovery journeys.

We were pleased to see the level of occupational therapy (OT) provision to the ward, which included occupational therapy technician staff, helped to optimise activity planning for patients on a one-to-one basis and in a group setting. This was evidenced in the patient's records, which detailed the OT assessments and recommendations.

Referrals, if required, could be made to physiotherapy, dietetics, podiatry or speech and language therapy to further support improved well-being. This provision, along with the local volunteer co-ordinator at Gartnavel Royal Hospital, has helped to ensure a variety of social activities to minimise any risk of isolation in the service.

We noted that there are three different psychiatrists providing cover to the ward, although we were not aware of this having an impact on the consistency of the care planned, and treatment delivered, to the patient group.

During our visit we found MDT meeting notes in all patient records for the ward. We heard from patients that they would routinely attend their MDT meeting and were included in discussions regarding their care. However, it was not evident in the records we reviewed that the patients were in attendance at the MDT; this was the same for named persons (NP) or the

patient's nearest relatives. We heard from management that NPs are invited to attend the MDT in person, or online; engagement with NPs and nearest relatives can help to facilitate clear communication and identify plans for all patients care.

Recommendation 1:
Managers should ensure there is consistency in the recording of attendance, participation and engagement of the patient, their families and named person at multidisciplinary team meetings.

There remains ongoing issues with the attendance of psychology and pharmacy staff at the MDT, due to demands on these professionals and vacancies. Despite this, we heard that both professions will attend when and where they can. Pharmacy staff are available for consultation, completion of medication reviews, and will spend time with patients discussing their medication if this is required. We heard that there was a consistency in the availability and attendance of social workers to aid with discharge planning for all patients, which ensured that there were no barriers to accessing timely outcome focused assessments.

Care records

Information on patients' care and treatment is held mostly on the electronic EMIS system. Some information is held in paper files although there are plans to eventually migrate all information over to EMIS.

The daily progress notes regarding patients care and treatment showed evidence of one-to-one input, or when additional support or medication was offered. There was also input from other professionals in these notes. During our visit to the service in 2017, we highlighted the need for clearer life story work and background. During this visit we were pleased to see that this was well recorded and easy to navigate for any visiting staff to the ward.

Use of mental health and incapacity legislation

When a patient is subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003, (the Mental Health Act), we would expect to see copies of all legal paperwork in the patient files. Part 16 (S235-248) of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments.

During this visit, we reviewed the certificates which record consent to treatment under the Mental Health Act (T2 and T3 certificates). We found these certificates in the patient's paper files. We were pleased to see clear and consistent recording of the legal authority and circumstances under which medication was being given.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (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. In reviewing patient's files, we were able to locate all applicable s47 certificates.

The vast majority of documentation relating to the Mental Health Act and AWI, including certificates, were available and up-to-date.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person (NP). Where a patient had a nominated NP, we found copies of this in the patient's file.

There was one patient who was subject to a guardianship order under the AWI Act. A copy of the order was located in the patient file. From discussions with staff it was positive to note that there was a clear understanding of what this order authorised.

Rights and restrictions

Kelvin House operates an open door policy. We were satisfied this was proportionate in relation to the needs of the patients. Although restrictions due to the Covid-19 pandemic have lifted, the ward continues to place the safety of patients at the forefront of any visits to the ward with the appropriate deployment of Personal protective equipment (PPE).

We were pleased to hear that where individuals were detained, they were aware of their rights and had access as and when required to advocacy and legal representation. We were informed that all patients detained under the Mental Health Act were referred to advocacy by their MHO and/or nursing staff.

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and they are written when a person has capacity to make decisions on the treatments they want or do not want in the future. Health boards have a responsibility to promote advance statements. From reviewing patient records, we found that there was a lack of consistent recording on when advanced statements had been refused by patients. We would encourage the service to revisit with all patients as the recording of advance statements is an important safeguard and a way of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts made to engage patients in a discussion regarding advance statements and the reason noted for any patient that does not have one.

The Mental Welfare Commission has produced advanced statement guidance which can be found at: https://www.mwcscot.org.uk/node/241

Recommendation 2:
Managers should ensure that there is a consistency in the recording of when advance statements have been offered and refused by patients in their notes.

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

Activities in rehabilitation wards are critical to ensuring recovery planning to support patient's reintegration into the community. We were pleased to hear of the importance of the activity coordinators in Kelvin House, and who that are employed to work flexibility with patients in and out with the ward environment. This resource ensured that there was an offer of support and activities for all patients that focused on discharge planning.

During our visit we were able to observe a full list of daily activities in the ward. Every patient we spoke with in Kelvin House was aware of the wide range of activities taking place in the ward including cooking groups, walking groups, darts groups, pool groups, relaxation, music, internet and film sessions. Since our last visit and the easing of Covid-19 restrictions, patients routinely leave the ward for therapeutic outings and activities across the central belt.

The files we reviewed contained comprehensive OT assessments and a weekly activity programme. In discussion with patients, the response to the range and level of activities was positive. Patients felt that the balance was right and that they enjoyed participating, while others commented that their choice not to participate was "respected" and they were supported at their own pace.

We heard about the close working links between the volunteer coordinators for Gartnavel Hospital and nursing and OT staff that has helped to deliver opportunities for patients. Managers acknowledged that many activities in the community, for instance bowling, swimming, had to stop due to the Covid-19 pandemic, although new creative ideas were put in place as well as re-establishing previously successfully activities for patients. The ward has close links with the Common Wheel project in Glasgow specifically designed to upskill people with mental health problems. As well as the restart project, there are close ties with the local garden centre which helps aid the gardening group in the ward. The ward holds community meetings once a week which plans for relaxation sessions, movie nights, shopping trips, walking, bowling and cinema outings. The activity coordinators work on finding activities that aid with the suitability of this work, and funding is in place by NHS Greater Glasgow and Clyde (NHSGGC) which ensures that items can be purchased to plan meaningful activities.

The physical environment

Kelvin Ward has 12 single bedrooms. Four of the bedrooms have access to en-suite shower and toilet facilities while the other eight have toilet facilities, with patients required to share shower rooms. Staff acknowledge that although the ward was adequate, this was not ideal. It is disappointing to note that patients who are in wards for prolonged admissions are required to share showering facilities which can compromise their dignity and privacy. Many wards across NHSGGC have been refurbished to provide patients with individual en-suite rooms.

In line with our last visit we were told that NHSGCC continue to review the totality of rehabilitation services due to the variations in the ward profiles across the estates. We continue to strongly encourage managers to consider the same for Kelvin ward. It should be noted that no patients raised any concerns regarding the current facilities impacting upon on their experience in the ward.

We found the ward environment to be calm and peaceful. This was demonstrated by the low lighting installed on the ward to help provide patients with a relaxed atmosphere. We were advised that the deployment of this lighting was utilised using am evidence-based Scandinavian approach which founds that patient's mental health tended to improve in less starkly lit and clinical environments.

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 in 2017 that the garden space should be cleaned and free from litter, and during our visit this continues to be well maintained. It was positive to note that a quiet room has been created by staff near the entrance to the ward to allow private visits for patients, their families, any young children and professionals. We found the room calm and relaxing and are pleased to see that there has been a focus on patients and their families experience when visiting the ward.

We noticed that a variety of staff rooms and patients bedrooms were looking tired with the fabrics of the rooms needing improvements. For instance, there were a variety of poster markings and paint that had worn away over time. We would expect that the general upkeep of the ward is managed via a regular maintenance programme. We would like to see improvements in these areas during our next visit. Despite the lack of some environmental improvements, we noted that the ward is in the process of having new flooring laid throughout the entire ward with plans to installed different coloured flooring in each patient room to personalise the environment. The aim of this flooring work is to divide the environment between communal areas and patients own rooms which again using the Scandinavian research has been found to help improve patient experiences. We were also pleased to hear that the tired curtains in the patient bedrooms were being replaced with new blinds, to help with infection control and offer more privacy. We were advised that all steps that have been taken in these areas are informed by the Scottish Patient Safety Programme.

Otherwise, the ward environment remains clean, tidy and free from any unpleasant odours. There is a fully equipped therapy kitchen available. It was positive to note that the recommendation from our last visit report to improve the active airflow and ventilation in the kitchen has been undertaken, which has ensured that patients undertaking tasks in this area find it much more tolerable.

In the activity room we could see the gym equipment, photography canvas, a new pool table, and a computer to assist patients to order online shopping, as well as a gaming console to provide patients with age appropriate outlets. These social opportunities continue to provide benefit when Covid-19 restrictions have an impact upon the ward.

During our last visit in 2020, and the in previous report in 2017, the treatment room for the ward was identified as a concern by the visiting staff. This was primarily due to the size of the room as it presented as it is cramped and not fit for purpose. Despite these concerns there have been no changes to these arrangements since these recommendations. We decided to review these concerns further with both staff and patients during our visit. Neither staff nor patients raised any particular concerns about the administration of any treatment they received from the treatment room or how medication is dispensed. It remains the case that

patients requiring any physical interventions including intramuscular medication administered, phlebotomy, ECG procedures, or any physical examination carried are performed at their bed space. Patients spoke of how all medication dispensed is administered in a planned way so no patients are routinely waiting around in a queue to obtain their medication. Due to the issues highlighted in previous reports we will continue to keep this area of care under review and revisit this matter during our next visit.

Recommendation 3:
Managers should ensure that the ward environment is fit for purpose with a regular maintenance programme in place with clear timescales for improvements.

Summary of recommendations

Recommendation 1:
Managers should ensure there is consistency in the recording of attendance, participation and engagement of the patient, their families and named person at multidisciplinary team meetings.

Recommendation 2:
Managers should ensure that there is a consistency in the recording of when advance statements have been offered and refused by patients in their notes.

Recommendation 3:
Managers should ensure that the ward environment is fit for purpose with a regular maintenance programme in place with clear timescales for improvements.

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.

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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