Mental Welfare Commission for Scotland

Report on announced visit to:

Timbury Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

Date of visit: 9 February 2023

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.

Timbury is a 25-bedded ward that provides a service predominantly for older adults with a functional mental illness. On the day of our visit, Timbury had 16 patients. The ward is situated on the first floor of a purpose-built hospital. We last visited this service on 5 May 2021 and made recommendations relating to care planning, activity provision and time out with the ward, recording of MDT meetings, recording of proxy decision makers and the environment.

The response we received from the service confirmed that the issues were being addressed.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how the service is adapting and developing as Covid-19 restrictions are lifted.

Who we met with

We met with, and reviewed the care of six patients, two who we met with in person and four who we reviewed the care notes of. We also met with/spoke with two relatives.

We spoke with the hospital manager, the senior charge nurse, the consultant psychiatrist, psychologist, physiotherapist and occupational therapist.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

What people told us and what we found

Care, treatment, support and participation

Timbury Ward utilised a multidisciplinary team approach. There were four consultant psychiatrists who worked with the nursing team, physiotherapists, occupational therapists, psychologist, and a pharmacist to provide person-centred care and discharge planning. In common with many areas of the NHS, there have been challenges in recruiting registered nurses, although the ward has utilised bank and agency staff to maintain staffing levels. The recently appointed acting senior charge nurse advised us that they have developed an orientation pack for staff who are unfamiliar with the ward.

At the time of our visit, there were two systems for recording patient information. EMIS recorded chronological and MDT documentation, Mental Health Act information and the majority of risk assessments electronically, with all other notes held on paper file. While this was not ideal, we were told EMIS would, in the future, be able to accommodate all information relating to patients' care and treatment. The majority of risk assessments had recently migrated over to the electronic system. We understood staff concerns of running with two parallel systems in creating difficulties and we look forward to seeing the implementation of a full electronic record keeping system, including nursing care plans. We heard that an electronic medication recording system (HEPMA) had recently been implemented.

On our previous visit we made a recommendation in relation to the quality of recording of MDT reviews. We were pleased to see that these now contained information on patient's progress towards care goals, decisions taken and actions required. We also saw evidence of carer's involvement and their views, along with those of the patient which were recorded. However, there was not a consistent record of who attended the meetings.

We previously made a recommendation in relation to care plans. On this visit we found detailed initial assessments and risk assessments were in place in all the files we looked at; these were reviewed on a regular basis. Care plans were person-centred and were being reviewed, however we found that care plans were not always being updated to reflect changes to care needs identified in reviews. Discharge plans were in place where appropriate, and patients and their families were involved in discharge planning and review meetings.

We saw that physical health care needs were being addressed and followed up appropriately.

We also found patients' one-to-one discussions with nursing and other MDT staff were clearly recorded.

Recommendation 1:
Managers should audit MDT review notes to ensure a list of staff in attendance is consistently recorded.

Recommendation 2:
Managers should audit care plans to ensure that these are updated to reflect changes in care needs identified within reviews.

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/node/1203

Use of mental health and incapacity legislation

On the day of our visit, three of the 16 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act ('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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

Where an individual had granted a power of attorney (POA) staff were aware of this and copies of the powers were on file or had been requested.

All documentation pertaining to the Mental Health Act and AWI acts including certificates around capacity to consent to treatment, where this was required, were in place and were up-to-date.

Rights and restrictions

Timbury Ward operated a locked door, commensurate with the level of risk identified in the patient group. There was a locked door policy in place and displayed beside the ward exit.

The ward had an open visiting policy out with protected mealtimes.

We heard that with the lifting of Covid-19 restrictions, decisions on opportunities for time out with the hospital, such as accompanied home visits, and outings with family members, were based on individual assessment of risk.

We saw posters advertising advocacy services on the ward notice board and were advised that the advocacy service is once again available on a face-to-face basis.

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/rights-in-mind/

Activity and occupation

During the working week, the ward benefitted from the daily input of two occupational therapists and an occupational therapy (OT) technician who delivered a service to the three care of the elderly wards on site, both for individual assessment, one-to-one therapeutic work and group activities, such as relaxation and crafts. We were told by the occupational therapist that their ability to provide group work and to use the therapeutic kitchen was severely restricted during the pandemic, however now that restrictions have been lifted, cookery groups were recommencing in the kitchen, albeit with smaller numbers; we heard that the OTs were keen to expand the range of activities they provide.

The physiotherapy service provided a strength and balance group once a week alongside individual assessment and one-to-one work. There were plans to expand the exercise programme to include Bongo Bingo classes. Prior to the pandemic, the ward had input from a number of external volunteers, including Common Wheel, who provided musical input, and Therapet services; we were pleased to see these had recommenced, and that there was a new music programme about to commence, which will provide basic lessons in playing a number of instruments over a 10 week period.

Throughout our visit we saw staff participating in activities with patients and found evidence of activity provision in the notes. There was an activity planner in the corridor that had information on the activities planned. However, unlike adult services, there was no dedicated activities co-ordinator post in the ward. We were told that while nurses provided activities on an ad-hoc basis, it was difficult for the nursing team to plan and carry out activities on a regular schedule due to the fluctuations in the levels of clinical activity and staffing levels.

Recommendation 3:
Managers should consider creating a patient activity co-ordinator post to support the ongoing development of activity provision within the service.

The physical environment

There were two lounge areas, an activity room and a separate dining area for the patients. However, the dining area was busy with 16 residents. We were pleased to see that thought had gone into meal presentation, with tables fully set with napkins etc, making for a pleasant dining experience for patients. We heard that when the ward is at full complement it is not possible to seat everyone for lunch in the dining room, and tables have to be set in the corridor or interview room to accommodate everyone at one sitting.

The ward environment was clean and bright, corridors were wide and the large windows provided good natural lighting. The layout of the ward consisted of single en-suite bedrooms. On our last visit we made recommendations in relation to the toilet flush and taps, which some residents found difficult to operate. We saw that sensors have since been fitted to a number of the toilets and sensor taps are being fitted to address this issue.

There is a large well-laid out enclosed garden that was directly accessible from the dining room and lounge. Landscaping work was underway during our visit to further improve this space.

We heard from the physiotherapist about a new alarm system which has been introduced to the ward. This comprised of sensors which could be fitted to bedroom and en-suite doors, pressure sensors on beds and chairs and movement sensors which could be fitted wherever they were needed. These were connected to pagers that discreetly alerted staff when they were triggered, allowing staff to respond quickly to patients who needed extra support or observation when mobilising, without the intrusion of placing them on constant observation. We heard that this was being monitored with an expectation that it would reduce the level of falls in the ward.

Any other comments

A number of nursing staff had recently undergone training in stress and distress management and in psychological therapies. The clinical psychologist, as well as providing individualised psychological therapies directly to the patients need, provided supervision for these staff as required. It was hoped that the range of therapies could be extended and more staff trained in over the coming year.

Summary of recommendations

Recommendation 1:
Managers should audit MDT review notes to ensure a list of staff in attendance is consistently recorded.

Recommendation 2:
Managers should audit care plans to ensure that these are updated to reflect changes in care needs identified within reviews.

Recommendation 3:
Managers should consider creating a patient activity co-ordinator post to support the ongoing development of activity provision within the service.

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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