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: 13 March 2024

Where we visited

Timbury is a 25-bedded unit that provides a service predominantly for older adults with a functional mental illness. The ward is situated on the first floor of a purpose-built hospital and provides individual rooms with en-suite facilities. It serves the west sector of NHS Greater Glasgow and Clyde, this includes West Dunbartonshire, part of East Dunbartonshire, and the western section of Glasgow City Council, including Knightswood, Drumchapel, and Whiteinch.

On the day of our visit, there were 21 people on the ward. We were advised that due to issues with medical staffing, and with there being three consultants instead of four, bed numbers had been capped at 20 patients. However, the ward could accept people boarded from the onsite adult wards as their consultant would retain responsibility for their care.

We last visited this service in February 2023 on an announced visit and made recommendations on multidisciplinary team reviews (MDT), care planning, and the provision of an activity nurse. The response we received from the service was that they were unable to employ an activity nurse as funding had not been provided for this, but that the other recommendations had been addressed and were continuing to be audited for compliance.

On the day of this visit, we wanted to follow up on the previous recommendations and look at communication with families.

Who we met with

We met with, and reviewed the care of seven people, six who we met with in person and one who we reviewed the care notes of. We also met with three relatives.

We spoke with the service manager, the lead nurse, senior charge nurse, charge nurses, consultant psychiatrist, and occupational therapist.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

We heard from nursing staff about the challenges they were currently facing because of high levels of clinical activity, with patients requiring significant input in relation to their physical health care as well as mental health support. This created particular challenges when set against a shortage of nursing staff because of vacancies and absence for a variety of reasons. We heard that, at times, this has had an impact on the nursing team in their ability to meet timescales for nursing reassessment, and in providing structured activity sessions. We were told that by those that we spoke with that they felt like "they are treading water". We heard that the service is awaiting the outcome of the older adult's service review, which will include recommendations for staffing establishments.

The three relatives, as with everyone that we spoke with, had no concerns regarding care in Timbury Ward. Relatives told us that they were not invited to MDT reviews, but did receive updates from nursing staff when requested and had spoken to their relative's consultant. We heard from individuals that they enjoyed the groups which were run by the occupational therapists.

Care, treatment, support and participation

Care records

Information on individuals' care and treatment is held in three ways; there is a paper file, the electronic record system, EMIS, and the electronic medication management system. Care plans and nursing reassessments are currently held in the paper system. MDT reviews and chronological notes are stored on EMIS along with Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) paperwork. NHS Greater Glasgow and Clyde (NHS GGC) are in the process of transitioning across to an electronic system.

We previously made recommendations in relation to care planning. During this visit, we found robust initial assessments and risk assessments in all of the records that we reviewed; these informed the person-centred care plans, which were regularly updated to reflect changes in needs and care delivery. Where discharge plans were being developed, there was evidence of social work involvement at the MDT and in the chronological notes. Physical health needs were addressed in care plans, and where necessary, referrals were made for investigations. We found occupational therapy assessments and care plans in the majority of files we reviewed; these were person-centred and gave a clear picture of the individual's skills and abilities.

Multidisciplinary team (MDT)

The ward has regular input from psychiatry, psychology, occupational therapy, and pharmacy. Other allied health professionals are available on a referral basis. MDT meetings are scheduled weekly, and are attended by the consultant psychiatrist, nursing staff, and psychology. We heard that the consultant provides feedback to patients following the MDT and telephones to give feedback to relatives.

We had previously made a recommendation in relation to recording of MDT meetings. We were pleased to find that all of the MDT notes we reviewed provided information on who attended, and a brief outline of decisions taken. We were told by medical and nursing staff that prior to the Covid-19 pandemic, individuals and their relatives regularly attended MDTs. This practice has not been re-established. However, this has been the subject of recent discussions with the team about how to address this. At the moment, there are systems in place to ensure relatives and individuals do receive feedback. We look forward to hearing at our next visit how the involvement of individuals and their relatives in the MDT and care decisions has progressed.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All detention paperwork was in place. The people we spoke to were aware of their detention and of their right of appeal.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, however we found two people were prescribed medication which was not authorised in the T3 certificate. This was discussed with the responsible medical officer/consultant for those individuals, who agreed to address this immediately.

Recommendation 1:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

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. We found section 47 certificates in the files we reviewed.

Rights and restrictions

Timbury Ward operates a locked door, commensurate with the level of risk identified in the patient group. Doors are controlled by a keypad and information on how to access/egress the ward was displayed beside the doors, alongside the locked door policy.

We saw posters advertising advocacy services on the ward notice board and were advised that the advocacy service is easily accessible. A number of the people we spoke with had made use of the advocacy service.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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 heard from the occupational therapist about the groups provided during the working week. The ward benefits from the daily input of two occupational therapists and an occupational therapy technician who delivers a service to the three care of the elderly wards on site, both for individual assessment, one-to-one therapeutic work, and group activities. These groups include relaxation and social outing groups, breakfast groups, newspaper groups and cookery groups.

The physiotherapy service provides a strength and balance group once a week alongside individual assessment and one-to-one work. There is input from a number of external volunteers, including Common Wheel, who provide musical input, and Therapet services.

Throughout our visit, we saw staff participating in activities with individuals 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 is no dedicated activities co-ordinator post in the ward. We heard that nurses provide activities on an ad hoc basis, which is difficult for the nursing team, as the ability to plan and carry out activities on a regular schedule has had an impact due to the current high levels of clinical activity and staffing pressures. We made a recommendation in relation to this in our previous visit report, but were advised by the hospital management that they were unable to act on this due to there being no dedicated funding provided for such a post.

Activity provision plays an important therapeutic role and the provision of an activity co-ordinator would provide a focus for this.

Recommendation 2:
Managers should ensure that activity provision is prioritised, so individuals have access to a range of therapeutic and social activities on a daily basis, to meet their needs and preferences. This should include progressing the provision of a dedicated activities co-ordinator post to facilitate this.

The physical environment

The layout of the ward consists of 25 ensuite bedrooms, two lounge areas, an activity room, and a separate dining area. We were pleased to see fresh flowers and plants in the dining room and the corridor areas. The ward environment was clean and bright, corridors were wide, and the large windows provided good natural lighting. There is a large well laid out enclosed garden that is directly accessible from the dining room and lounge. Landscaping work has been completed and garden furniture has been installed making this a pleasant, welcoming space.

Summary of recommendations

Recommendation 1:

Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

Recommendation 2:

Managers should ensure that activity provision is prioritised, so individuals have access to a range of therapeutic and social activities on a daily basis, to meet their needs and preferences. This should include progressing the provision of a dedicated activities co-ordinator post to facilitate this.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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