

Mental Welfare Commission for Scotland

Report on unannounced visit to: Timbury and Cuthbertson
Wards, Gartnavel Royal Hospital, Great Western Road,
Glasgow, G12 0XH

Date of visit: 6 November 2018

Where we visited

Cuthbertson and Timbury Wards are admission wards for older adults. Cuthbertson has 20 beds and provides assessment and treatment for individuals with a diagnosis of dementia. Timbury has 25 beds and provides a service predominantly for individuals with a functional mental illness, although there can be admissions of patients with dementia which can be problematic. On the day of our visit, Timbury had 13 patients and Cuthbertson had 11 patients.

The wards are situated on the first floor of a purpose-built hospital and provided individual rooms with en-suite facilities. They are similar in layout and offer bright and spacious facilities with a number of sitting rooms, separate dining room, and activity space. Both wards have an enclosed garden space which was directly accessible from the dining room.

We last visited this service on 30 October 2017 and made the following recommendations: care plans for stress and distress should be person centred; life history information should be a core part of care planning for patients with a diagnosis of dementia; there should be a programme of activities to meet the interest and needs of patients, and information on how to access and exit the ward should be displayed.

On the day of this visit we wanted to follow up on the previous recommendations and also look at compliance with mental health and adults with incapacity legislation.

Who we met with

We met with and/or reviewed the care and treatment of 12 patients.

We spoke with the senior charge nurses and staff nurses in both wards.

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

Margo Fyfe, Nursing Officer

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We were told that, in addition to medical and nursing staff, pharmacy and occupational therapy staff attended multidisciplinary team meetings. There were also good links with community psychiatric nurses and social workers, who attended meetings as

required. There was ready access to allied health professionals on a referral basis. However, there was no dedicated psychology input.

Within Timbury Ward, although some care plans viewed were person-centred, there was a lack of consistency in the quality of care plans. Where care plan reviews could be found they lacked detail, and there were long periods of time between reviews.

Within Cuthbertson Ward we found 'Getting to Know Me' forms containing life history information in most of the files we reviewed. Where this had not yet been completed the reasons were documented.

Care plans within Cuthbertson Ward were person-centred and addressed both mental health and physical health needs. Where individuals experienced stress and distress, there were detailed care plans which contained information on personal triggers and effective distraction and de-escalation strategies. In one case, the Newcastle model had been used. We were advised that nursing staff were trained in the use of this model, but the absence of psychology input impacted on the ability to develop detailed formulations.

Within both wards carers were kept informed and actively encouraged to be involved in decisions about care, either through attendance at multidisciplinary reviews or through meetings with the named nurse or consultant. However, within Cuthbertson Ward we found two 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms which had been completed without evidence of this having been discussed with the next of kin or proxy decision maker.

Recommendation 1:

Management should ensure that there is a consistent approach to the development and review of care plans, and this should be audited.

Recommendation 2:

Managers should ensure that medical staff consult appropriately with carers/next of kin/proxy decision makers, and record this, when completing DNACPR forms.

Use of mental health and incapacity legislation

Within Timbury Ward there was some uncertainty around the legal status of one patient who was subject to detention under the Mental Health (Care and Treatment) (Scotland) 2003 Act. None of the nursing staff was clear about the patient's status and agreed to check this further with medical records, and clarify and amend the patient records.

Within Timbury Ward we also found two patients who were recorded in the notes as having a power of attorney in place. However, no copies of the powers were on file.

In Cuthbertson Ward, within the files we reviewed, where there was a guardianship or power of attorney in place copies of the powers and the contact details of the proxy were on file.

Within both wards, within the files we reviewed, where they were required we found consent to treatment certificates which authorised the prescribed treatment.

Recommendation 3:

Managers should provide training on mental health and incapacity legislation to ensure staff understand the powers and any restrictions in place for individual patients. Where there are proxy decision makers, this must be recorded and the proxy decision maker consulted as appropriate.

Rights and restrictions

Within both wards, the door was keypad entry and egress. Patients within Timbury were given the exit codes following risk assessment. Relatives were given the keypad entry number on a patient's admission. There was no notification around the doors of these being locked, or a locked door policy.

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/>

Recommendation 4:

Managers should ensure that a locked door policy is in place, and information on how to access and exit the ward is available to patients and visitors.

Activity and occupation

Within Timbury Ward we saw one small group activity led by an occupational therapist (OT) in the morning of the visit. There was an activity notice board which advertised when outside agencies were visiting, which stated that activities would happen on an "ad hoc basis". We were told that a nursing assistant is being given the role of responsibility for activities and will make up activity timetables and allocate responsibility for these throughout the staff group.

They had also just bought activity provisions and were in the process of changing the female sitting room, which was rarely used, into an activity room. Within Cuthbertson Ward we were told there was dedicated OT provision, and we saw evidence of the OT-led activity programme. There was also a small group of four staff who were leading on the development of recreational activities within the ward. This included evening and weekend activities such as movie nights, outings, and various small group activities. The ward had also received an increase in socialisation budget to support

this. A band 5 patient activity co-ordinator had recently been appointed and will start work next month. Their role will include the co-ordination of activity provision and development of psychosocial activities. We were advised that the impact of this post will be evaluated over the coming months. We look forward to seeing evidence of the impact of the increased activity resource during our next visit.

Recommendation 5:

Managers should ensure that activity provision is prioritised within Timbury Ward so patients have access to a range of therapeutic and social activities to meet their needs and preferences.

The physical environment

Within Cuthbertson Ward the environment was dementia-friendly, with appropriate signage on toilets and bathrooms and use of colour on handrails and toilet seats. However, there was nothing to orientate patients to their own bedrooms. We are advised that whilst pictures had been used previously for this, they were often removed or damaged by patients. The ward is currently exploring other options, including the use of memory boxes or Perspex picture holders outside each room.

Work was underway in Cuthbertson Ward to improve the patients' environment. This included purchasing radios for each bedroom. An additional large smart TV had been provided but it was not yet in use, due to difficulties in obtaining an appropriate portable stand. The ward had a range of sensory equipment and was currently awaiting new blinds for one of the rooms to enable this to be set up as a sensory room. We look forward to seeing these improvement on our next visit.

The showers within the en-suite shower rooms were fixed-head showers which were not suitable for individuals who are confused or physically frail and may require assistance with personal care. We were advised that it is planned to replace these with shower heads which can be adjusted or hand-held, which will better meet the needs of the patient population.

Summary of recommendations- change as above

1. Management should ensure that there is a consistent approach to the development and review of care plans, and this should be audited.
2. Managers should ensure that medical staff consult appropriately with carers/next of kin/proxy decision makers, and record this, when completing DNACPR forms.
3. Managers should provide training on mental health and incapacity legislation to ensure staff understand the powers and any restrictions in place for individual patients. Where there are proxy decision makers, this must be recorded and the proxy decision maker consulted as appropriate.
4. Managers should ensure that a locked door policy is in place and information on how to access and exit the ward is available to patients and visitors.
5. Managers should ensure that activity provision is prioritised within Timbury Ward to ensure that patients have access to a range of therapeutic and social activities to meet their needs and preferences.

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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