



Mental Welfare Commission for Scotland

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

Date of visit: 30 October 2017

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 we are advised that they are receiving an increasing number of admissions of individuals with a diagnosis of dementia. The wards are based in a purpose built hospital and provide individual rooms with en-suite facilities. They are similar in layout and offer bright and spacious facilities with easily accessible garden space. We last visited this service on 29 July 2014 and made recommendations around: activities, personalisation of bedrooms, entrance and sitting areas, lockable drawers, and access to the public phone.

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

Who we met with

We met with and or reviewed the care and treatment of 14 patients/residents, and met with two carers/relatives.

We spoke with the service manager, senior charge nurse, charge nurse, and staff nurse.

Commission visitors

Mary Hattie, Nursing Officer, (visit coordinator)

Mary Leroy, Nursing Officer

Paul Noyes, Social Work Officer

Katherine Taylor, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

Each of the wards is served by four consultants. There is dedicated occupational therapist (OT) provision in both wards. Psychology, physiotherapy, dietetics, and speech and language therapy are all available by referral.

The multidisciplinary team (MDT) review notes give a clear record of attendance and decisions made. Whilst patients do not generally attend the MDT reviews, there is feedback to them by the consultants and nursing staff, and there is good evidence of

family involvement in decisions. Feedback from relatives we spoke to was that staff were approachable and they felt able to be involved.

We were told that there is a monthly carers support group within Cuthbertson, and that the triangle of care standards are in place.

Risk assessments were thorough and reviewed regularly. Care plans were well evaluated and reviewed. However, when looking at care plans for managing stress and distress we found that the quality of these varied considerably.

Within Cuthbertson, staff were using the Newcastle model for managing stress and distress, and care plans reflected this. Although, the level of information they contained varied with some requiring more detail around the strategies which worked for the individual.

In Timbury ward, where there were care plans for stress and distress, there was no person-centred information around the specific triggers or strategies for distracting or de-escalating.

We were advised that the recording of life history information for patients with dementia had 'fallen by the wayside', and that relatives were sometimes reluctant to complete this. The provision of good quality life history information, which can inform care planning, is essential for patients with a diagnosis of dementia.

Physical health care was good, chronic health issues were being managed and monitored, and patients referred for investigations where appropriate.

Recommendation 1:

Managers should ensure that care plans for management of stress and distress need to be of a consistent standard, containing relevant person-centred information about appropriate techniques and strategies to use.

Recommendation 2:

Managers should ensure that for patients with a diagnosis of dementia a record of life history information should be a core part of their care plan.

Use of mental health and incapacity legislation

Where it was appropriate, certificates of incapacity (s47) and treatment plans were in place. Certificates authorising treatment (T3) were in place and covered all treatment. Detention paperwork was in place. There was a standard sheet in use with information about commencement and expiry dates, and reminders of when consent to treatment certificates (T2) and T3 would be required.

Rights and restrictions

The entry to both wards was by a keypad system. Staff controlled entry and egress; where patients were informal and able to leave the ward safely, they were either given the keycode, or could ask staff to let them out. There was however no information advising patients of this.

Within Cuthbertson ward some individual bedroom doors were locked for periods of time. This was individually assessed and was based on risk.

One relative made comment that the fixed visiting times in Cuthbertson ward were restrictive, however we were advised by staff that, where it is requested, visiting is allowed outwith the set visiting times.

Timbury told us they offered flexible visiting.

Advocacy were involved with a significant number of patients in both wards, with all detained patients within Cuthbertson being referred.

Recommendation 3:

Managers should ensure that there should be a locked door policy, and information on how to exit or access the ward should be clearly displayed.

Activity and occupation

On our visit we found that Timbury ward had no activity programme, and no dedicated activities staff. We were advised that activities are provided on an *ad hoc* basis by nursing staff, when clinical workload allows. On the day of our visit a number of patients were involved in a quiz group.

Within Cuthbertson, ward there is an activity plan and the OT technician assists with activity provision, with nursing input when clinical demands allow. Both wards have regular fortnightly input from Therapet, and monthly input from a music group.

We have previously made recommendations about the need to ensure there is equitable activity provision and individual activity programmes within these wards, this doesn't appear to have been acted on.

Recommendation 4:

Managers should ensure that each patient has access to a programme of meaningful activities to meet their interests and mental health needs. This should be recorded and audited to ensure they take place. Consideration should be given to the provision of dedicated activity staff to facilitate this.

The physical environment

Both wards were clean, bright and spacious, and have good access to a variety of garden areas.

Within Timbury there was little personalisation of bed areas, and the ward felt quite clinical and stark. In contrast, within Cuthbertson, there has been a lot of work undertaken to improve the environment and make it more dementia friendly. The US collective, who specialise in dementia design and art projects have been working with Cuthbertson ward for a year. They have introduced colour into the ward and appropriate wall art has been provided. In each patient's bedroom, there is an area where the patient can put up their own photos. There are a few pieces of appropriate furniture to encourage good posture and make it easier to rise from the seat, encouraging mobility.

We had previously made recommendations that the keys to lockable drawers within patients' rooms should be provided where individuals wish. This has been done.

Summary of recommendations

1. Managers should ensure that care plans for management of stress and distress need to be of a consistent standard containing relevant person-centred information about appropriate techniques and strategies to use.
2. Managers should ensure that for patients with a diagnosis of dementia, a record of life history information should be a core part of their care plan.
3. Managers should ensure that there should be a locked door policy, and information on how to exit or access the ward should be clearly displayed.
4. Managers should ensure that each patient has access to a programme of meaningful activities to meet their interests and mental health needs. This should be recorded and audited to ensure they take place. Consideration should be given to the provision of dedicated activity staff to facilitate this.

Good practice

We were very impressed with the improvements to the environment within Cuthbertson to make it more dementia friendly and welcoming.

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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