Mental Welfare Commission for Scotland

Report on announced visit to:
Gartnavel Royal Hospital, Timbury and Cuthbertson Wards, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 27 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Timbury Ward 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.

Cuthbertson is a 20-bedded unit that provides assessment and treatment for older adults who have a diagnosis of dementia. Both wards serve the west sector of NHS Greater Glasgow and Clyde (NHS GGC); this includes West Dunbartonshire, part of East Dunbartonshire, and the west sector of Glasgow City Council, including Knightswood, Drumchapel, and Whiteinch.

On the day of our visit, there were 17 people on Cuthbertson Ward and Timbury Ward was full.

We last visited these wards in March and June 2024 and the visit to Cuthbertson Ward was unannounced. We made recommendations in relation to person-centred care planning and information, recording of multidisciplinary team (MDT) meetings, legal authorisation of medication, activity provision and the recording of this.

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

Who we met with

We met with and reviewed the care of 14 people, eight who we met with in person and six who we reviewed the care notes of. We also spoke with four relatives.

We spoke with the senior charge nurses (SCN), charge nurses, the psychiatrist, psychologist, lead occupational therapist and occupational therapist, the lead physiotherapist and physiotherapist and the volunteer co-ordinator.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

Justin McNicholl, social work officer

Gemma Maguire, social work officer

What people told us and what we found

The relatives we spoke with told us staff were approachable and they had no concerns regarding the care their loved ones received. One relative told us “I love it here; I wish he could stay here forever”. Others mentioned staff members who they felt really understood their family member’s needs and “went the extra mile” to meet these. We heard about the entertainment that was available and how much their loved ones enjoyed it. We heard from relatives that they were able to attend the MDT meetings or could speak to nursing and medical staff about any concerns, or when decisions were made, they could discuss these by phone or during visits if this suited the relative better.

The individuals in the wards that we were able to speak with were very positive about staff and the care they received, telling us “staff are great”, “they keep my family updated”, although one individual did say “night staff aren’t as understanding of my needs as day staff”.

We heard from both physiotherapists that communication in the MDT was excellent, with good information sharing and everyone working together towards the reduction of falls and in improving mobility.

The volunteer co-ordinator told us that Timbury Ward was the only admission ward in Gartnavel Royal Hospital that did not have a dedicated patient activity co-ordinator post, but that despite this absence, staff do what they can. They also told us that funding for the Common Sheel music project that has been very active and valued in the hospital was coming to an end; we heard how much this will be missed.

Care, treatment, support, and participation

Care records

Information on individuals’ care and treatment was held in three ways; there was a paper file, the electronic record system, EMIS, and the electronic medication management system, HEPMA. Care plans were stored on EMIS; this is a recent change. MDT reviews and chronological notes were also stored on EMIS along with risk assessments and paperwork associated with the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) paperwork such as section 47 certificates and guardianship or power of attorney documentation was held in the paper file and scanned into the documents section of EMIS.

We previously made recommendations in relation to care planning in Cuthbertson Ward. During this visit, in both wards we found robust initial assessments and risk assessments in all the records that we reviewed; these informed the care plans, which were clearly person-centred. Physical health needs were addressed in care plans.

We saw that care plans were being updated to reflect changes in a person's needs and in the care delivery, however care plan reviews were inconsistent in their quality and frequency. In a small number of the care records we reviewed, we were unable to find care plan reviews.

Recommendation 1:
Managers should audit care records to ensure that care plans are regularly and meaningfully reviewed.

We found occupational therapy (OT) assessments and OT care plans in most of the files we reviewed; these were person-centred and gave a clear picture of the individual's skills and abilities. In Cuthbertson Ward, we found completed 'Getting to know me' documentation in all the files we reviewed. This document contained information on an individual's needs, likes and dislikes, personal preferences and background that enabled staff to understand what was important to the individual and how best to provide person-centred care while they are in hospital.

We had previously made a recommendation in relation to care planning for the management of stress and distress. Where an individual experiences stress and distress, we would expect to see a care plan outlining the potential triggers, effective de-escalation strategies and threshold for use of as required medication for that individual. On this visit we were pleased to find detailed person-centred care plans for the management of stress and distress for individuals where this was an issue.

We heard from the psychologist that a number of registered nurses were undertaking a two-day course on the management of stress and distress, and it was hoped that most of the health care assistants would be able to attend training on the essentials of stress and distress in the near future. We were told that the ward was preparing to participate in an NHS Education for Scotland (NES) initiative to improve practice in relation to the management of stress and distress.

On occasion, medical staff will decide that due to physical health conditions or frailty, cardiopulmonary resuscitation would not be in the best interests of an individual. In such circumstances the doctor would be expected to discuss this decision with the person or their relative/proxy decision maker if the person lacked capacity and then complete a DNACPR form. Such forms should be reviewed on a regular basis and when there are changes in the person's physical or mental health. In Timbury Ward, we did find two care records where the individual's health and capacity had changed since the form had been completed. These needed to be reviewed, and this was highlighted to the SCN and charge nurse at the time of the visit.

Recommendation 2:
Managers should put an audit system is in place to ensure that DNACPR forms are correctly completed indicating who was consulted, and that these are reviewed on a regular basis.

The Commission has published a good practice guide on care plans[1]. 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.

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 were scheduled weekly and attended by the consultant psychiatrist and nursing staff; other disciplines attend or provide reports as appropriate and when they attended the meetings, this was recorded. We heard that relatives were given the opportunity to attend MDTs or provide their views prior to the meetings. We noted their participation was recorded in the MDT notes.

The MDT records were clear and concise, setting out decisions taken, actions agreed and who was responsible for implementing these. Consultation with proxy decision makers was also clearly recorded.

We were told that there were nine patients across both wards whose discharge from hospital was delayed, either due to the delay in the granting of guardianship orders that would authorise their placement in another care setting or due to difficulties in finding a suitable placement. In one case, the individual had been ready for discharge for over two months but had still to be allocated a social worker; this will be followed up. We heard from staff that despite there being a dedicated delayed discharge team in place, it was difficult to get information about any progress, or what the reasons for the delay was. We heard that copies of assessments compiled by social work were not being shared with the nursing team despite this being requested. Staff advised us that on occasion, the social work reports shared with care homes focussed on the individual's presentation prior to admission and did not accurately reflect the person's most recent presentation, resulting in care homes refusing admission.

Recommendation 3:
Managers should review communication between the delayed discharge team and ward staff to ensure that the reasons for delays and copies of social work assessments are shared with the nursing team.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Use of mental health and incapacity legislation

On the day of this visit, 11 people were detained under the Mental Health Act.

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 and corresponded to the medication being prescribed.

In relation to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), where the person had granted a power of attorney (POA) or was subject to a guardianship order, copies of the powers were available in all but one of the files we reviewed. We were told that a copy of the powers had been requested. There was evidence in the chronological notes and MDT minutes of consultation with proxy decision makers in relation to care and treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 s47 certificates in place for adults who required this, and proxy decision makers had been consulted appropriately.

For those individuals who were receiving covert medication, covert medication pathways were in place.

Rights and restrictions

Both wards operate a locked door, commensurate with the level of risk identified in the patient group. Doors were controlled by a keypad and information on how to access/egress the wards were displayed beside the doors, alongside the locked door policy.

We saw posters advertising advocacy services on the ward notice board and were advised that this service was easily accessible.

Both wards operated an open visiting policy, and we heard that relatives were supported to be involved in their loved one’s care at mealtimes or in other ways should they wish.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We had previously made recommendations in relation to activity provision in Timbury Ward and the recording of activities in Cuthbertson Ward.

On this visit we were pleased to see that a varied activity programme continued to be delivered in Cuthbertson Ward, led by the patient activity co-ordinator (PAC) and activity provision, and that this was more clearly recorded. We noted an improvement in activity provision in Timbury Ward despite there being no dedicated PAC. We were told that there were plans being considered to reallocate resources in the nursing budget to fund and recruit to a part-time PAC post.

Recommendation 4:
Managers should progress the provision of a dedicated activities co-ordinator post in Timbury Ward to address the inequity of provision across the service and ensure a regular activity programme can be developed and maintained.

The occupational therapists provided a service across both wards, undertaking assessments and providing individual activity sessions and several group activities, including a breakfast group, a walking group, a newspaper group, relaxation sessions and in conjunction with the psychologist, a cognitive stimulation group was provided.

During our visit, there were visiting musicians and this was enjoyed by those who were in the wards. We also saw several posters around the wards advertising musical activities over the next few weeks.

The physical environment

Both wards were bright, spacious and in good decorative order. The layout of the wards consisted of ensuite bedrooms, two lounge areas, an activity room, and a separate dining area

There were several quiet spaces as well as the larger sitting areas. There was dementia-friendly signage throughout the wards and artwork on the walls and windows that included pictures of old Glasgow that added interest to the environment.

Cuthbertson Ward had two pleasant secure garden areas, directly accessible from the ward area. A hospital gardener volunteered their services to the ward to help maintain the space. We saw that some new garden benches had been installed and

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

heard that there were plans for further improvements to the garden areas to make them more attractive for people to use.

This ward also has a dedicated activity room and a sensory room that houses an interactive table. This room did not have curtains on the large windows and for much of the time it is not possible to use the activity table or other sensory equipment due to the brightness level. We were told that curtains were ordered for this room several years ago and took over a year to arrive. The ward has now been waiting for over two years for the curtain rails to be fitted and the curtains to be hung despite several requests to have this addressed. On our previous visit we were told that the service was the awaiting fitting the curtains and we had expected to find these in place. It is disappointing to find that this has still not been addressed given the limits this puts on people's ability to benefit from the use of the sensory room and its equipment.

We noted that there was a lack of comfortable seating in several of the bedrooms and the small TV room was very sparsely furnished with only a couple of chairs and no table. We were told that additional seating and tables have been requested on numerous occasions by the SCN, but that due to procurement difficulties these have never been provided. Timbury Ward staff also advised us that they had experienced difficulties with procurement of equipment that needed to be replaced.

Recommendation 5:
Managers should ensure that requests for necessary furniture, fittings and equipment are addressed promptly to provide an appropriate environment and enable the sensory room to be fully operational**.**

Timbury Ward had a large, well laid out, enclosed garden that was directly accessible from the dining room and lounge. Landscaping work had been completed, and garden furniture had been installed making this a pleasant, welcoming space.

During the visit, we noted a number of people smoking in the garden. There is legislation in place which prohibits smoking on hospital premises and there were notices advising that this was in place around the hospital grounds. Staff told us that they do advise people of the policy and offer smoking cessation support, nicotine patches etc. However, if some individuals refuse to comply with the policy and continue to smoke in the gardens staff were not clear on what action they could take.

Recommendation 6:
Managers should provide support and guidance for staff on how to manage noncompliance with the smoking ban on hospital premises.

Summary of recommendations

Recommendation 1:
Managers should audit care records to ensure that care plans are regularly and meaningfully reviewed.

Recommendation 2:
Managers should put an audit system is in place to ensure that DNACPR forms are correctly completed indicating who was consulted, and that these are reviewed on a regular basis.

Recommendation 3:
Managers should review communication between the delayed discharge team and ward staff to ensure that the reasons for delays and copies of social work assessments are shared with the nursing team

Recommendation 4:
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Recommendation 5:
Managers should ensure that requests for necessary furniture, fittings and equipment are addressed promptly to provide an appropriate environment and enable the sensory room to be fully operational**.**

Recommendation 6:
Managers should provide support and guidance for staff on how to manage noncompliance with the smoking ban on hospital premises.

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 an individual's care, treatment, and support are 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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