Mental Welfare Commission for Scotland

Report on announced visit to: Clyde House and Kelvin House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 25 March 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

The rehabilitation service in Gartnavel Royal Hospital consists of two wards, Clyde House and Kelvin House.

Clyde House is an 18-bedded high dependency, mixed-sex intensive rehabilitation ward providing care and treatment for adults with severe and enduring mental health problems. Clyde House also provides hospital-based complex care for a small number of people and can be used as an overflow ward when the general psychiatry wards are full. At the time of our visit there were 15 beds in use in Clyde House; three beds were not in use as one person had sole use of a four-bed dormitory area to meet their physical healthcare needs.

Kelvin House is a 12-bedded rehabilitation unit providing care and treatment for adults with severe and enduring mental health problems. On the day of our visit, there were nine people in the ward, six of whom were rehabilitation patients and three of whom were people receiving out of sector care (meaning that the wards that they would normally be in were full).

We last visited Clyde Ward in September 2022 on an announced visit and made two recommendations. The first was that managers should ensure that the ward environment was welcoming, fit for purpose and for the service to provide the Commission with an update on the programme for refurbishment, including timescales. The second was that managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

We last visited Kelvin Ward in November 2022 on an announced visit and made three recommendations. Firstly, that managers should ensure there is consistency in the quality of the care plans, that they better evidence patient involvement and that they were regularly reviewed. Secondly, that managers should review the adequacy, safety and effectiveness of the ventilation in the therapy kitchen and lastly that managers should review the adequacy and safety of the treatment room and the need to perform all physical health procedures in the individual's bedroom area.

On the day of this visit, we wanted to follow up on the previous recommendations and hear from people about their experience of care and treatment.

Who we met with

We met with and reviewed the care of 10 people, eight who we met with in person and seven who we reviewed the care notes of. We also met with/spoke with six relatives.

We spoke with the service manager, the senior charge nurses (SCNs), the lead nurse, the occupational therapist, the liaison nurse, and a consultant psychiatrist.

In addition, we met with nursing staff and healthcare support workers in the services.

Commission visitors

Andrew Jarvie, engagement and participation officer

Sheena Jones, consultant psychiatrist

Gemma Maguire, social work officer

Paul Maquire, nursing officer

Catriona Neil, higher trainee

What people told us and what we found

The people we spoke to told us that “staff bent over backwards” to help them and that they “felt safe” there. People said that the services were “better than the last ward” they were in and that the “staff were great”. People said that staff kept them updated and included them in ward meetings. One person said that they “were actually learning new skills here”.

One relative told us that their family member had been doing well in a single room but had been “set back” by moving into a dormitory. The carer felt that their view was not listened to. We also spoke to senior staff about this, and they advised that the person had not been able to leave hospital as planned due to a change in their functioning and that the change of room was considered to be necessary after an assessment of the clinical needs and risk to the person and others in the ward.

Care, treatment, support, and participation

We heard from senior staff that people often tell them they prefer being in the rehabilitation services as the wards tended to be quieter and less busy. We heard that every effort was made to involve people and their families and carers in their care and treatment. We heard that some people don’t have or want family involvement in their care and treatment and for those that do, it can be hard for them to attend weekly ward meetings. Some families preferred to attend the quarterly review meetings and knew that they could speak to the nursing staff at any time in between.

There was also a weekly referral meeting where referrals from Gartnavel Royal and Stobhill Hospitals were discussed with regards to people’s specific rehabilitation needs and which service can best provide that care and treatment. People who were likely to require longer periods of rehabilitation may be more suitable for the service in Clyde House; Kelvin House tends to offer a recovery programme for people who do not need to be in hospital for so long.

We met with the liaison nurse for Clyde and Kelvin Houses and heard about their work. They run a carer support group and offer a range of support to families and carers. The liaison nurse and other members of the MDT are trained in a range of psychological therapies including cognitive remediation therapy, social cognitive and interaction training (SCIT), and cognitive behavioural and family therapy in group settings or on a one-to-one basis. We heard how the liaison nurse supported individuals to identify and attend vocational activities in their own communities, linked with housing, financial and benefits services and also had links with social work and community services. They also supported people on discharge from hospital until such time as they had established links with local community mental health services.

We heard from senior staff in Clyde House that they provide a regular patient newsletter to share information about the service with people and their families and carers. There had been a regular community group in Clyde House in the past and that this could run again in the future should it better meet the needs of the people in the service.

We heard there was a regular community group in Kelvin House, and we saw evidence of this in the information boards in the service.

Care records

We reviewed electronic care records held on EMIS in Clyde and Kelvin Houses. These were easy to access and contained a wide range of information about each person. We saw information about people's physical health, health assessments, mental health, detailed risk assessments and information about the person's legal status and their wishes with regards to information sharing.

We saw that each person had a face-to-face meeting with nursing staff and a record of their contact was regularly recorded. We saw that there was daily recording of the person's progress and their activities each day and that people were spending a lot of time out in the community as their health, skills and independence improved.

We saw that each person had a person-centred care plan (PCCP) in their records that used a standard PCCP template. This included a wide range of physical and mental health care needs in addition to rehabilitation, social and cultural goals. We saw that the information in the PCCPs was detailed, relevant to each individual, regularly reviewed and updated and that each person was involved in these processes through the one-to-one meetings with the MDT and at the weekly MDT meeting.

We could see that the PCCP developed during the time that the person was in the rehabilitation services and as their health and independence improved, they were more able to take part in this process. For people who were more unwell or at the start of their rehabilitation, we found that the care plans were often written in formal and professional language, but we could also see that nursing staff had met with people to talk about what was important to them.

We saw that the PCCPs included things like what the person liked to do on a good day and what they found helpful to do on a bad day. We also heard that people could have plain English versions of their care plans, if they wished, and that a few people had requested these and chose to keep their own copies.

Multidisciplinary team (MDT)

There were well resourced multidisciplinary teams working in Clyde and Kelvin Houses, with some professionals working across both services.

We heard that there were members of staff who had worked in rehabilitation services for many years and had expertise and experience of working towards recovery with people.

We heard that there were no issues with recruitment and that recent vacancies had been advertised.

The MDTs included nursing, occupational therapy, psychiatry, psychology and physiotherapy. The nursing team includes registered nurses, health care support workers (two of whom functioned as activity co-ordinators) and the liaison nurse. There was also a technician who supported the occupational therapy service.

People's physical health was looked after by a local general practice service with regular GP visits to the wards. We could see that people's physical health and health screening was well managed from the care records.

We heard that in both services there was a weekly multidisciplinary meeting involving the multi-disciplinary team (MDT) to which people, families and carers were invited. We heard that people met with nursing staff prior to the meeting, to think about what had happened over the previous week and the things that they wanted to talk about at the meeting.

We reviewed the MDT meeting minutes and related care records on the electronic care record system (EMIS) and could see regular recording of the meetings between people and nurses to prepare for the MDT meetings and regular and detailed recording of the MDT meetings. This included information about who attended, how the person had been feeling, their physical and mental health, their involvement in activities over the previous week and the action plan for the coming week.

We heard from the MDT that people's social workers could also attend MDTs and review meetings, and we saw evidence of this in care records.

In addition to the MDT meeting, there is a monthly service improvement meeting which was attended by all disciplines in the multidisciplinary team (MDT). This meeting was used to identify, discuss and review any service improvements or innovations.

Use of mental health and incapacity legislation

On the day of the visit, eight people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) in Clyde House and six people were detained under the Mental Health Act in Kelvin House.

All documentation relating to the Mental Health Act and Adult with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were easily found in the electronic records and were up to date.

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.

All consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were reviewed. These were found in the electronic care record system, and we also saw that there was a helpful alert on the system to advise the user that they were in place. Paper copies of all T2 and T3 forms were also held in a folder in Clyde and Kelvin House, and we compared these with the medication prescribed for each person on the electronic prescribing system, HEPMA.

In Clyde House we reviewed one T2 form and seven T3B forms. In two cases we found that the medication prescribed on HEPMA exceeded that authorised on the T3B forms. It was evident that the higher dosage of medication had not been given in either case and after we spoke to the medical staff the medication dosages were adjusted accordingly.

In another case we found that there was a regular medication prescribed that was not authorised on the T3B. We ensured that the relevant psychiatrist was advised of this error and provided them with information about how they should address this.

One person in Clyde House was prescribed medication by injection as required and we discussed with the medical team the authority for this given that the person was not subject to the Mental Health Act.

We were informed by senior staff that nursing staff in Clyde Ward undertake a regular weekly audit of T2 and T3 forms.

Recommendation 1:
Managers and the multidisciplinary team for Clyde Ward should ensure that medical treatment is appropriately authorised in accordance with responsibilities under Part 16 of the Mental Health Act.

In Kelvin House we reviewed three T2 forms and three T3B forms and found that all medication being prescribed had the appropriate authority.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We could see that there was ongoing discussion with people about the named person role and that this was regularly recorded in the care records.

Rights and restrictions

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275

and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements.

We could see that there had been a lot of work undertaken in Clyde House, in particular with regards to advance statements; there was a lot of information available for people on the information boards. We could also see that there were regular discussions about advance statements with people that was recorded in the records, and we saw ongoing work about developing these with people when they were ready.

When we reviewed certificates authorising treatment under the Mental Health Act, we noted that one person was receiving treatment that went against what they had written in a newly updated advance statement. We spoke to the consultant psychiatrist, and they advised that it was not clear that this medication would continue. We shall follow this up in due course.

We could see information about local advocacy services on the noticeboards in the ward and could see that people were meeting regularly with advocacy services as needed. We heard that the local advocacy service had visited Clyde House recently to meet with people and talk about their role.

The Commission has developed *Rights in Mind.*[1] 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

During our visit we could see that there were many activities on offer to the people in Clyde and Kelvin Houses. These included a range of ward-based one-to-one and group activities and other activities were available on the hospital site, with social and vocational activities on offer in the nearby community and in people's home areas.

The notice boards in both Clyde and Kelvin Houses shared a wide range of information about these activities, along with a weekly timetable of activities available and information about other vocational services that were also available.

We heard that each person had their own weekly timetable for activities that was reviewed at the start of each week. People could keep their own copies of their individual activity plans, and we also saw copies of these in a folder for the nursing staff.

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

In people's care records, we could also see regular assessments for each person in relation to their activities of daily living and how their activities linked with their rehabilitation goals and the actions from the MDT meeting each week.

Activities that were available in Clyde and Kelvin Houses included arts and crafts, jewellery making, board games, movie and documentary film sessions and gardening. Groups included a 'something to get up for' group, soup making and a breakfast group. The ward community meeting in Kelvin House included a relaxation session which everyone, including staff, could attend. We also saw information about a visiting therapy pet.

We heard that people could access a local gym and be referred to their own local council gym using the Live Active system. There was a community café, a local singer's group and the Restart service, which gave people the opportunity to learn joinery and picture framing skills. People also attended the activities provided by Flourish House.

The MDT also spoke to us about the importance of identifying activities in each person's local community rather than local to the hospital, so that they could establish those routines and community links before they left hospital.

The physical environment

Clyde House was a long building with ramp access to its main door. On one side of the building was the bedroom and office space. The other half of the ward had all the activity, servery and lounge areas.

In the entranceway, and throughout the wards, we saw noticeboards providing a wide range of information about activities, legislation, people's rights, the MDT, carers groups, community resources and therapeutic activities. We also saw resources in relation to recent work undertaken in the services about advance statements.

Clyde House had a large therapy kitchen which was spacious and well equipped. It was open all day and people could access hot drinks, cereal, toast and snacks, in addition to using this kitchen to prepare their own meals. There was a large open plan servery, dining room and day room which had dining tables and chairs, a pool table, a television, and a range of activities.

There was also a large activity room across the corridor with access to an enclosed and well-maintained garden space to the rear. The activity room had a movie projector screen, a range of DVDs, an air hockey table, jigsaws, and arts and craft activities available.

The garden space was welcoming and had garden furniture and healthy plants. There was some evidence of people smoking in the garden area, which is not in line

with smoking regulations. We were told that staff would re-direct people smoking in the garden space away from the hospital building, and that a sensitive approach was required to maintain therapeutic relationships with people.

In Clyde House, the bedroom area consisted of three dormitories with four beds in each. The dormitories shared toilet and shower facilities. There tended to be one male dormitory area and one female dormitory area. The third dormitory can be male or female depending on demand. The remainder of bedrooms were single occupancy. These had their own toilet and sink and shared shower access. There was also a large bright bathroom in the main corridor that everyone could use.

For this visit, it was evident that there had been a programme of repair and redecoration since our last visit, in line with the recommendations that we had made. Clyde House was clean, bright and well decorated and the fittings were generally in good repair. There were areas of flooring and one wall that was damaged. We spoke to the service manager, and they felt that progress was being made to have these fixed. We were also told that some planning was required to undertake repairs as the work that was required would prevent people from accessing those areas at that time.

We also heard that there were some concerns about the impact of ligature reduction work and policies on people's activities of daily living as staff were required to keep charging cables and charge people's electrical devices for them. This did not appear to have the same negative impact in Kelvin House where a more person-centred and flexible approach allowed people to keep their own cables following a risk assessment process. We were told that the different approach in the two services reflected the more complex needs of some people in Clyde House and that they require longer periods of rehabilitation. We look forward to hearing an update as to the ongoing discussions with managers about these issues in due course.

Kelvin House also had ramp access to its main door at the centre of the building. It consisted of a long corridor with rooms along its length. We saw that the ward corridors were lit with low lighting as the main ward lights were very bright and clinical.

At one end of the ward there were two bedrooms with a small sitting area that tended to be used by people who had progressed through their rehabilitation and were working towards discharge. The two bedrooms were adjacent to a sitting area which was a bright area with a small sofa. Next to this were double doors leading outside and a storeroom.

Along the corridor was the ward kitchen and servery which formed a large open plan space with the ward day room. There were tables and chairs, sofas, a television, and games and activities in this area. We also saw a notice board with information about

advocacy and for carers. Next to this was the ward's therapy kitchen which was a large, bright and well-equipped area where people could freely access hot drinks, breakfast foods and snacks. We heard that most people in the ward chose to cook every day and that they would be supported in the planning and cooking of food by occupational therapy and nursing staff.

As noted, the ward entrance was in the centre of the ward where there was a small quiet room, a toilet and baby changing facilities for visitors.

In addition to the notice board we saw in the day area, there were also boards in the service entrance and along the ward corridor which provided information about activities in the service, activities in the community, and social and vocational group activities.

The ward activity room was a big, bright space with a laptop, pool table and games console. It had gym equipment that people could use after an initial induction by physiotherapy staff, and a range of books, games and films. From the activity room the enclosed garden space was accessed via a door and ramp. This was a well-maintained area with garden furniture and planters that could be used by people in better weather. The work from previous gardening projects was evident.

Beyond the activity room was the nurses' station, the treatment room and a number of offices. There was a well-equipped laundry which people accessed on a rota basis. The remainder of the ward comprised the bedroom areas. There were four bigger rooms which had their own shower and shared a communal sitting area. The remainder of the bedrooms were not en-suite, although had their own toilet and sink and shared adjacent showers.

Summary of recommendations

Recommendation 1:
Managers and the multidisciplinary team for Clyde Ward should ensure that medical treatment is appropriately authorised in accordance with responsibilities under Part 16 of the Mental Health Act.

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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