Mental Welfare Commission for Scotland

Report on announced visit to: Intensive Psychiatric Care Unit (IPCU), Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 13 May 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Routemap (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face with in-person interviews on the ward and telephone interviews with relatives on the day and post-visit.

The Intensive Psychiatric Care unit (IPCU) is a 12-bedded purpose built facility in Gartnavel Royal Hospital. An IPCU provides intensive treatment and interventions to patients who present with an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

We last visited this service on 25 April 2019 and made the following recommendation: managers should ensure that all medication prescribed is authorised with T2 or T3 authority in place where required, and processes are in place to audit this.

On the day of this visit we wanted to follow up on the previous recommendation and also meet with patients and speak with their relatives. We also wanted to hear from staff of their experience of caring for patients during the Covid-19 pandemic. This is because we were aware from local intelligence that in-patient services saw a significant rise in mental illness acuity. Furthermore, with restrictions in place there was a reduced opportunity for patients to have input from voluntary therapeutic activity services, psychology and importantly visits from relatives and friends.

On the day of this visit there were 10 patients within the unit, all of whom were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act). Over the past 12 months we were aware from local intelligence patients who were subject to mental health provisions of the Criminal Procedure (Scotland) Act 1995 ('the CPSA Act') had their court hearings delayed. We were told this was because the number of court hearings had significantly reduced during the height of the pandemic. Patients and their Responsible Medical Officers (RMO) had found the delays increasingly difficult in light of restrictions placed upon patients in this environment.

We were pleased to hear all patients who were waiting for their hearings have now attended court and have now moved on from IPCU.

Who we met with

We met with and/or reviewed the care and treatment of seven patients and by telephone we spoke with three relatives.

Prior to our visit we met with the senior charge nurse (SCN), charge nurses, and the service manager. On the day we met with one of the charge nurses and other members of the nursing and care team.

Commission visitors

Anne Buchanan, Nursing Officer

Dr Gordon Skilling, Consultant Psychiatrist

Kathleen Taylor, Engagement and Participation (Carers) Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit the ward was calm and quiet. Staff told us there is a recognition this is not always the case and depends upon the patient population at any given time. Patients seemed comfortable in the company of staff and were happy to approach them.

We were told there has been an increase in the use of bank and agency nursing staff. There has recently been a large number of nursing staff securing posts in community settings. This loss of nursing staff as well as the pandemic has meant recruiting into these posts has been challenging.

We were told by one patient that not having consistent staff overnight can be difficult, especially during times when they are distressed. While bank and agency staff were available, they do not always know the patients as well as the core team. We are aware there are several vacancies throughout the hospital including IPCU. There are weekly multidisciplinary team (MDT) meetings with weekly reviews recorded on the electronic record system EMIS.

IPCU, as with all wards across the Gartnavel Royal Hospital site, still record information on paper and EMIS. While there have been additional forms placed on the electronic system, this is not fully operational. We agreed with staff this is not ideal having to work between two systems and look forward to seeing EMIS as a platform for recording all patient's notes and records.

Contact with medical staff happens every week however patients will be reviewed more frequently as required. We spoke with one relative who was very positive about their contact with medical staff. They appreciated regular updates from the Responsible Medical Officer and felt included in their relative's care and treatment. For another relative they described their interactions with staff as generally supportive especially during times when visiting was restricted.

Patients we spoke to were generally positive about their care and treatment in IPCU. While most patients spoke of feeling safe and listened to, one patient felt staff did not take into account their past experiences. We would expect staff to have undertaken training to ensure the delivery of care is trauma informed and where emergency medication is required, this is administered in a way that does not cause unnecessary distress.

We reviewed electronic and paper records including risks assessments, care plans, daily progress notes, and MDT meetings minutes for each patient we interviewed. We noted that while each patient had care plan(s) specific to their individual needs, there was little evidence of patient participation. We recognise patients who are exceptionally unwell may not be in a position to contribute fully with creating their care plan. However, we do believe it is important that every effort should be made to ensure patients are provided with opportunities to engage with the process and there is recorded evidence of participation.

The Commission has published a good practice guide on care plans. 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, and can be found at: https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Nursing staff update a patient's progress on EMIS; this is a daily record that offers details of the patient's presentation, any changes in their presentation, and an opportunity to obtain the views from the patient about their care and treatment. We would like to have seen more detail in progress notes, while the daily narrative could have been expanded to offer a greater description of the patient's presentation or progress. This would have added a richness to the content while also providing a greater appreciation for staff who are perhaps not familiar with the patients, for example bank and agency staff.

We discussed the value of regular audits of care plans, risk assessments and progress notes. We were told the charge nurses would take responsibility for this and discuss findings with keyworkers. Unfortunately, this has not been as consistent due to staffing issues; however we would encourage charge nurses to commence regular audits to promote quality improvement.

During our last visit to IPCU we discussed the role of psychology and were pleased to hear funding had been made available and patients were benefiting from psychology input. Over the past 12 months, input from psychology has not been available for face-to-face assessments or therapy due to Covid-19 restrictions. Input has largely taken place 'virtually.' We hope psychology will be available for patients' in-person as we recognise psychological formulations perform an important part of a patient's care and treatment.

Use of mental health and incapacity legislation

On the day of our visit all patients were subject to the Mental Health Act. We were able to locate all relevant paperwork on EMIS.

For those patients subject to compulsory treatment, we checked whether consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. We noted two patients had medication not authorised by a T3 form. We brought this to the attention of the charge nurse. We were informed the RMO has contacted the Commission to request a visit from a designated medical practitioner as both patients had recent amendments to their treatment.

Rights and restrictions

This IPCU is a locked ward and has a 'locked door policy' which is proportionate with the level of risk being managed within an intensive care setting.

On the day of our visit there were two patients who required additional support with enhanced observation from nursing staff. We were told that patients who are subject to enhanced observations are reviewed daily. The clinical team discuss the patient's care and treatment to

determine whether the patient's observation level can be safely reduced. Patients are encouraged to participate with their safety plan and this is recorded within their file.

We are aware due to the increase in the use of bank and agency staff there may be a risk of patients feeling ill at ease with unfamiliar staff. Enhanced observation requires therapeutic engagement from staff to the patient. Staff should view this level of observation as an opportunity to engage in activities with the patient to enable a therapeutic relationship rather than simply observing a patient movements around the ward area.

All patients continue to have access to advocacy, albeit this has had to be adapted due to Covid-19 restrictions, and has not been through the usual face-to-face contact. Those that we spoke to who had requested input from advocacy had been able to do so either through the ward electronic device or via telephone.

Patients we spoke to were aware of their right to legal representation. Nursing staff provide contact details of lawyers and opportunities for patients to meet with their legal representative. While in-person meetings have been hampered due to the pandemic, patients do have access to telephones or electronic devices to ensure they can keep in touch with their legal representative, family and friends.

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/law-and-rights/rights-mind

Activity and occupation

We were told activities undertaken by volunteers had to be suspended until recently. On the day of our visit the volunteer co-ordinator along with an individual from Music-In-Hospitals were entertaining patients in the ward's garden. This occasion being the first visit following easing of Covid-19 restrictions appeared to be greatly appreciated by patients and staff who welcomed the return of the musician into their ward. We were told volunteers would soon be re-starting their sessions and the activity programme would include therapeutic contributions from local artists, musicians, gardeners, and the return of the popular therapet visits.

Nursing staff over the past 12 months have contributed hugely to an activity programme that had been previously undertaken by occupational therapy (OT) team and volunteers who had offered a wide variety of activities. While some activities had to temporarily cease due to Covid-19 restrictions there were opportunities for nurses to work with patients or with groups to engage in relaxation, fitness programmes in the ward gym, crafts and other recreational activities.

Occupational therapists continue to provide comprehensive functional assessment of needs with care plans which were person-centred and regularly reviewed and updated. Furthermore, the OT technician along with the patient activity co-ordinator provide input that is highly regarded.

The physical environment

This ward is purpose built and is light, spacious, well-decorated and well maintained. The ward consists of 12 single en-suite bedrooms and a large communal seating area with additional quiet sitting room. There is an activity room, gym with a variety of exercise equipment and meeting rooms which can be used for family visits. One relative we spoke to would have preferred to engage in activities during their visit. They felt having to meet with their relative in a small room with a set of chairs was not conducive to a relaxing visit. If there were opportunities to play a board game or play pool they felt the interactions would be more natural.

The entrance to the ward was an area a relative wished to discuss. They would like to see photographs of staff as a way of identifying who staff are and their role within the ward. While they appreciate the significance of charts evidencing certain aspects of cleanliness of the ward. They would have preferred to read a description of IPCU's ethos, their values and ambitions for enabling recovery.

Good practice

We were told nursing staff have played an active role in supporting colleagues in the adult mental health wards on the hospital site. By providing an outreach model with assistance from the Scottish Patient Safety Programme, this has reduced the number of admissions to IPCU. Nursing staff from IPCU provide guidance, advice and support earlier in a patient's admission thus potentially avoiding an admission to this intensive care ward. We look forward to hearing more about this initiative during our next visit.

Service response to recommendations

There are no recommendations in this report, therefore no response from service is required.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON
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 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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