Mental Welfare Commission for Scotland

Report on unannounced visit to:

Portree Ward (IPCU) Stobhill Hospital, 133 Balornock Road, Glasgow G21 3UZ

Date of visit: 28 September 2022

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 route map. 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 for a time we were undertaking mainly virtual visits. This local visit was carried out face-to-face.

Portree is the intensive psychiatric care unit (IPCU) situated in McKinnon House at Stobhill Hospital. This is a 12-bedded unit for patients aged 18-65, which provides intensive treatment and interventions to nine male and three female patients, who present an increased level of clinical risk and require an enhanced 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 the service on the 21 May 2019, and made two recommendations, one regarding the nursing of patients in their rooms which required to be documented with clear rationale, and the second regarding the fabric of the de-escalation room, in particular the flooring. The response we received from the service advised us that clear discussions had taken place with the multidisciplinary team regarding the care planning and that adherence to policy now ensured those nursed away from their rooms were fully risk assessed and reviewed. In relation to the de-escalation room, the service advised us that new flooring was fitted, and the room was painted to make it more comfortable for patients.

On the day of this visit we wanted to meet with patients, their relatives, follow up on the previous recommendations, and hear about the impact of the Covid-19 pandemic upon patients' care and treatment.

Who we met with

We met with and reviewed the care and treatment of all 11 patients in the ward and spoke with six relatives either in person, or via telephone.

Prior to the visit we spoke with the service manager, the senior charge nurse and one of the deputy charge nurses. On the day of our visit we met with two charge nurses who were able to provide us with updates on the ward.

Commission visitors

Justin McNicholl, social work officer

Mike Diamond, social work officer

What people told us and what we found

As our visit was announced, patients, relatives, and staff were prepared for our visit and we were given full access to the ward, in order to meet with patients and staff. The majority of patients we spoke with were satisfied with the nursing and allied health professional's care and support provided. They spoke positively of staff "going out of their way" to support them, to improve their quality of life and mental health. It was clear that patients generally felt the benefit of the care offered to them, and to ensure that whenever possible, recovery was at the heart of the care delivered.

The ward has input from one consultant psychiatrist and one staff grade psychiatrist who has a specific remit for the ward. We heard from nursing staff that that there is a high ratio of staff to patients; this is particularly important in an IPCU ward where there are increased levels of clinical risk and patient needs can be complex. There were two patients on one-to-one/continuous interventions at the time of our visit. Due to the level of observations in place and vacancies, the ward was having to utilise bank and agency staff, as well as healthcare assistants to ensure there was adequate cover for the ward. A concern is that this has led to a reduction in experienced staff being readily available at all times to manage patient care.

The main concerns brought to our attention related to the lack of communication from medical staff to patients on what was expected from them in order to move on from the IPCU. These frustrations were notably echoed by carers and relatives, who highlighted their annoyance at the lack of opportunities to meet with the treating team on a regular basis, to understand what were the identified goals for patients that would ensure a safe transition from the IPCU to other wards, or to return home. Patients also reported being unable to access activities on and off the ward, due to staff shortages.

The majority of relatives praised the care delivered by the staff, but highlighted the lack of communication from the lead clinicians. They told us that it required considerable energy on their part to arrange meetings with the registered medical officer in charge of their relative's care. This, coupled with the lack of activities on offer for patients and the need for the environment to be improved due to the concerns we found on the day, made us aware that action that was required in order to improve the patient journeys through the service, as these matters were adversely affecting patient's mental health.

Care, treatment, support and participation

On the day of our visit, the ward was busy due to the number of patients confined to the ward. Under normal circumstances there are usually twelve patients, however due to accommodating a young person on the ward, it was agreed that the ward capacity would be reduced to eleven patients to meet competing demands of the patient group.

It was apparent that despite this, there were a significant number of staff available to support patients who were struggling with their mental health. The level of proactive engagement and care planning for patients appeared to be helping to manage and de-escalate any associated risks. Of the interactions we witnessed many of these were warm, friendly and respectful. The patients we met with expressed their frustration and at what they described as "confusion" as to why they remained confined to the unit. There was limited evidence in the care notes on what explanations were being given by the lead clinicians to patients; patients described

themselves as being "stuck", when from their perspective, they were ready to move onto other wards, or be discharged home. We will follow up this issue with the lead clinician separately.

We noted that due to the number of complex mental health conditions evident in the IPCU, the use of the multi-purpose de-escalation room along with one to one observations is required to manage distressed behaviours. On the day of our visit some patients expressed their frustration, anger and resentment towards the lead clinicians for their care as they indicated that unnecessary delays were causing many of their behaviours and actions.

Recommendation 1:
Managers should ensure that a clear rationale and communication is offered and recorded to ensure that patients understand why they remain suitable for care in an IPCU.

We reviewed the majority of care plans which gave details around the interventions used to support improved mental health. We found that many of the care plans were repetitive, generalised and not personalised. The care plans did not capture the complexities of the patients we met with and the care that was being given to aid in their recovery. We recommend that all care plans are reviewed to ensure a more personalised and meaningful recording is documented that captures the care we observed. The Commission has published a good practice guide on care plans. It is designed to help staff create person-centred care plans for people with mental ill health, dementia or learning disability, and these can be found at:

https://www.mwcscot.org.uk/node/1203

Recommendation 2:
Managers should ensure there is patient involvement and participation in care planning which is personalised, to ensure that this is evidenced in each care plan.

We were pleased to see personalised risk assessment and management plans to treat some of the most vulnerable patients on the ward. The assessments and plans were easy to access with clear rationale on what support achieves the best outcomes for patients.

We noted that there was one patient who was particularly vulnerable due to their age and stage of life. Under normal circumstances a young person would not be routinely supported in the IPCU due to their level of vulnerability. Despite this, it was clear that considerable thought and preparation had been put into delivering high quality care to the patient. This was reflected by the discussion we held with this patient's family who reported that "the staff are amazing". We did note that the young person was not being supplied any input from the local education department on the ward. This was not in keeping with the young person's wish to access further education. Had care and treatment been provided in a young person's unit, access to education would have been provided on-site. The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out that all young people should have access to education when subject to the Act.

Recommendation 3:
Managers should ensure that all young people who are subject to care in the IPCU, should be able to freely access education without any barriers, if they are well enough to participate in education activity.

Multidisciplinary team (MDT)
All patient care is reviewed at a weekly MDT meeting. On reviewing these records, there was evidence of input from medical, nursing, allied health professionals, social workers and other disciplines. Actions and outcomes were clearly recorded in each patient's MDT forms, and documentation was detailed, and of a high standard. However, information relating to communication with patient's named persons and their nearest relatives was not completed. We found limited recording of interactions with patient's families, which was confirmed when we met with them. Some relatives spoke of having no interaction with the lead clinicians for long periods.

Recommendation 4:
Managers should ensure regular participation and engagement with the patient, their families and named persons in regard to multidisciplinary team meetings.

There was evidence of input from psychology, with psychological formulations being undertaken, and outcomes shared with the MDT to assist with their understanding of a patient's presentation and behaviours. Physical health screening was evident, assessments were ongoing, and care plans related to physical health needs were detailed.

There are currently two systems for recording documentation. EMIS is the electronic record that holds the majority of care files including daily notes, chronologies and MDT documentation. The rest of the patient record is held on paper file. As noted in our last report, this is not ideal as it separates patient information which is at risk of being lost. The goal for the service is for all information to be on EMIS, which would end the need for paper files. We had hoped this would have been achieved since our last visit in 2019, but to date, this remains a work in progress.

Of the 11 patients on the ward at the time of our visit, five had been in the ward for less than three months which is as we would expect to see, as patients should spend as short a period of time as is possible in an IPCU. We consider that any long-term placement of patients in the IPCU ward is concerning, as it is not in-keeping with good patient care and treatment.

Use of mental health and incapacity legislation

On the day of our visit, all 11 of the patients in the IPCU were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 (CPSA). The majority of the orders in place were under the Mental Health Act. The appropriate detention paperwork was readily available.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. We found the appropriate consent forms in place for the patients that needed them.

Where an individual lacks capacity in relation to decisions about their financial affairs we found that the paperwork relating to management of patient finances were in order. There were three patients having their affairs managed by the NHS to ensure appropriate budgeting and safeguarding in place.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are subject to detention in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed. There were two patients on the day of our visit who were subject to these procedures and we were told that these arrangements are reviewed weekly at the MDT, to determine whether the restrictions in place are still required.

Our specified persons good practice guidance is available on the Commission website at:
https://www.mwcscot.org.uk/node/418

Rights and restrictions

Portree is a locked ward and has a 'locked door policy' which is proportionate with the level of risk being managed in 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 advised that patients who are subject to enhanced observations are reviewed daily. The medical and nursing team discuss the patient's care and treatment to determine whether the observation level can be safely reduced. Patients are encouraged to participate with their safety plan and this is recorded in their file. On the day of our visit we observed patients who were subject to enhanced observations being cared for throughout the ward environment; this was a noted improvement compared to our last visit when patients were being cared for in their bedrooms away from other patients.

We were told that patients are provided with information about how to access independent advocacy and provided with contact telephone numbers for legal representation. Unfortunately during our visit we spoke with five patients who had not been referred to, or were able to access advocacy, by either their Mental Health Officer or by the ward. As a result they were not fully aware of their rights.

Recommendation 5:
Manager should ensure that patients have access to advocacy services at all times whilst subject to any provisions of mental health legislation.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. We found limited evidence of any advance statements for any patients in the IPCU. Staff on the ward were aware of the legal function of advance statements however, there was no apparent promotion of advance statements in the ward. The Mental Welfare Commission has produced advance statement guidance which can be found at:
https://www.mwcscot.org.uk/node/241

Recommendation 6:
Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinical notes and care plan.

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

Activities for patients in IPCU wards are important due to the level of restrictions they face. On the day of the visit we did not see much activity happening in the ward, although there appeared to be staff available to help facilitate if activities were identified. We did however find that some social opportunities and activities were recorded in continuation notes. This included access to the gym and the ward gardening group. Input from a physiotherapist and occupational therapy staff had provided physical health assessments in order for patients to return to their previous level of abilities prior to discharge from hospital. Patients told us that when deemed fit for access to activities, they enjoyed the one-to-one therapeutic activities and escorted time away from the unit.

We discussed the issue of social opportunities for the patients with managers and it was acknowledged that activity has suffered due to staffing issues across the service. We were informed of plans to employ a new therapeutic activity nurse to work flexibility with patients. This would ensure that there is an opportunity for all patients to engage in activities. We look forward to seeing the development of this post, along with an improved activity programme when we next visit the ward.

We were advised of the consistent support supplied to the ward by occupational therapy, physiotherapy and dietetic staff who provide group work and one-to-one sessions to patients. Patients spoke of having time out of the ward to attend swimming, church and other community activities independently or with their families. The unit benefits from having its own enclosed garden that is landscaped with plants and shrubs. We were told that the gardening group encourages patients to spend time outdoors while maintaining the garden's plants and shrubs.

The physical environment

The ward consists of 12 single en-suite bedrooms. There are three seating areas, a dining room, an activity room, a family room, and a small gym which provides access to the occupational therapy department. The ward decor was bright and reasonably well maintained. We were pleased to note that the recommendation from our last report regarding the condition of the de-escalation room had been addressed with new flooring and improved décor.

On the day of the visit we were very concerned to hear from patients that they had to sleep in their clothes with large blankets to maintain their body heat. This was due to the heating system in the ward not functioning correctly. We were informed by nursing staff that a repair to a component in the ward boiler had been ordered but had not yet been received. This delay

appears to have been an ongoing issue for some time which has had an impact on the patient's comfort while in the ward. On the day of our visit a number of the rooms felt cold and unwelcoming due to the ward temperature. The issue of lack of heating was further compounded by the fact that the ward washing machine was not functioning correctly. As a result patients were found wearing layers of stained clothes to keep warm. Staff and patients reported that they were required to use washing machines in the adjacent wards which was also having an impact on rehabilitation opportunities for patients. We were advised that some families had taken it upon themselves to take their relative's clothing home to wash it themselves. We were assured on the day following our visit that immediate action would be taken to address both the broken boiler part and the lack of a functioning washing machine.

Recommendation 7:
Managers should ensure that all maintenance and improvement works are carried out urgently to meet the basic standards of care for the benefit of all patients.

Summary of recommendations

Recommendation 1:
Managers should ensure that a clear rationale and communication is offered and recorded to ensure that patients understand why they remain suitable for care in an IPCU.

Recommendation 2:
Managers should ensure there is patient involvement and participation in care planning which is personalised, to ensure that this is evidenced in each care plan.

Recommendation 3:
Managers should ensure that all young people who are subject to care in the IPCU, should be able to freely access education without any barriers, if they are well enough to participate in education activity.

Recommendation 4:
Managers should ensure regular participation and engagement with the patient, their families and named persons in regard to multidisciplinary team meetings.

Recommendation 5:
Manager should ensure that patients have access to advocacy services at all times whilst subject to any provisions of mental health legislation.

Recommendation 6:
Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinical notes and care plan.

Recommendation 7:
Managers should ensure that all maintenance and improvement works are carried out urgently to meet the basic standards of care for the benefit of all patients.

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.

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 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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