Mental Welfare Commission for Scotland

Report on announced visit to:

Tiree, Coll and Barra Wards, the Priory Hospital, 38-40 Mansionhouse road, Glasgow, G41 3DW

Date of visit: 4 October 2023

Where we visited

The Priory Hospital, Glasgow is a 32-bedded psychiatric hospital. The hospital currently has a 23-bedded eating disorder facility (Coll and Barra Wards with 14 and nine beds respectively), and a private inpatient mental health unit (Tiree Ward with nine beds), providing inpatient care to individuals with mental disorder, such as depression, anxiety and/or substance misuse.

On the day we visited, Coll Ward had three empty beds, with Barra and Tiree Wards each having one empty bed. Managers advised the Commission staff that plans were in place for Tiree Ward to have further three beds, taking the ward to a 12-bedded unit.

Since our last visit, Tiree Ward no longer accepts admissions for individuals with severe mental disorder, such as those who experience psychosis. We were advised care and treatment will be provided for individuals who become more unwell during an admission, but they will look to transfer care to acute NHS mental health facilities, including anyone who requires the use of Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

We last visited Coll and Barra Wards on 8 July 2021 and Tiree Ward on 9 July 2021, and made recommendations about authorisation for medication, activity provision and disability access to one of the wards.

On the day of our visit, we wanted to follow up on the previous recommendations and any progress made. We also wanted to speak with patients, staff and carers and listen to their views on the care, treatment and environment.

Who we met with

We met with and reviewed the care of 19 patients, and we reviewed a further care record of one individual.

We met with the therapy service manager, therapy team leader, senior charge nurses (SCNs), charge nurses and staff nurses.

We also spoke with one relative on the day of the visit.

Commission visitors

Gemma Maguire, social work officer

Susan Hynes, nursing officer

Dr Margaret Whyte, medical officer

Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support and participation

Feedback provided by individuals was positive and staff we spoke with had good knowledge of those they cared for.

Staff were described as 'friendly', 'kind' and 'go out of their way to help'. Many individuals reported the service provided 'excellent' care. One individual stated "by far the best care and support to help me recover", and another advised "having access to excellent therapy doesn't happen anywhere else." Individuals reported to enjoy a range of leisure activities and psychological based therapies such as art therapy, mindfulness and cognitive behavioural therapy.

When we last visited, there were positive reports from individuals regarding participation in their care and treatment plans. We were pleased to hear this has continued with most individuals feeling listened to in all aspects of their care. Some individuals had signed copies of care plans and others described, in detail, their care plan goals. Where individuals disagreed with care plans, they were aware of their rights, for example making a complaint, and views were clearly recorded.

Many individuals across the hospital felt 'listened to', 'respected', and 'valued 'by staff. It was reported that the 'suggestions box' and fortnightly 'community meetings' were a good way to provide feedback on care-related issues, such as activity and food choices. Staff were described as 'approachable' and many discussed issues on a one-to-one basis. Some individuals reported disagreement and/or concerns with staff members, including medical staff but were aware of their rights, for example following complaints procedures.

A relative we spoke with on the day of the visit said they were appropriately consulted and included in case conference meetings. For some individuals on Coll and Barra Wards, family and friends lived long distances away, such as England, so making regular face-to-face contact difficult. Some choose not to have face-to-face contact, with relatives believing it was too distressing to be separated when they leave. Many of the individuals we spoke with did not live nearby and commented on the lack of specialist eating disorder support in their home areas.

Individuals we met with felt contact with their family was well supported and were happy with their relative's involvement in their care. For those working towards discharge, family involvement was evidenced in feedback and review of electronic records. One relative we spoke with commented "the staff really prepared me for helping them at home," and "without the staff, they would not be alive."

We were pleased to learn that work has been ongoing on developing a carer/family support group, with one meeting taking place earlier this year. Whilst this was poorly attended, staff were continuing to consider ways to encourage better participation from carers and families, with carers awareness training be rolled out to staff. We look forward to hearing of the progress regarding carers support and staff training at our next visit.

Care planning
Since our last visit, there has been a service-wide change to the electronic template used for recording care plans. Care plans are now divided into four specific areas: keeping healthy, keeping connected, keeping safe and keeping well. The care plans we reviewed were person-centred with individualised and detailed goals, particularly in Barra and Coll Wards. In Tiree Ward, we noted that despite individuals reporting benefit from learning new skills in group work, such as managing distress, this was not consistently recorded in care plans.

From the staff and individuals that we spoke with, there was evidence that reviews of care plans were being carried out, however the recording did not reflect this. We were informed the new care plan template is a 'live' document (meaning any update overrides previous recording), making progress and reviews difficult to record and audit.

Several individuals we spoke with had diagnoses of an eating disorder as well as other conditions such as autism. Most reported that staff were understanding and supportive of their needs. We heard from an individual who was diagnosed with autism and another who had diabetes that staff awareness and understanding of non-eating disorder related issues varied, and at times was 'lacking'. Having discussed this with senior charge nurses and charge nurses, we were advised that training for autism is a requirement for all staff. In relation to diabetes, specialist diabetes nurse consultation was provided from an individual's home area. Staff did comment that the provision of specialist care from local Health Boards, for non-eating disorder related issues, can be variable. It was reported by nursing and therapy staff, they can access a variety of training to benefit in patient care. We reviewed records of all individuals we met with and there was evidence of care plans addressing specific needs.

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/node/1203

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure consistent recording of person-centred goals and progress made.

Multidisciplinary team (MDT)

At the time of our last visit, some individuals in Coll and Barra Wards felt the clinical team could focus more on trauma rather than weight and BMI numbers. We are pleased to hear that most individuals we met with reported a trauma-informed approach was used across the MDT, with a good balance between working towards a target weight and engagement in therapeutic interventions.

In Coll and Barra Wards, MDT meetings continue to be held weekly for all individuals, and case conferences take place every four weeks. Individuals meet with their named nurse twice weekly and consultant psychiatrist weekly. The MDT has three consultant psychiatrists, a resident hospital doctor (who carries out physical health reviews, blood tests, day to today reviews and prescribing), psychology, occupational therapy, dietetics, and pharmacy. MDT and case conference records were reviewed and there was evidence of detailed recording

from each MDT member. Views from individuals, families/carers and other agencies including social work and Mental Health Officers were also available.

Use of mental health and incapacity legislation

When we last visited, recommendations were made in relation to ensuring medication prescribed under the Mental Health Act was appropriately authorised, reviewed, and audited. We further recommended that all medical staff should urgently request second opinions from a designated medical practitioner (DMP) when issuing consent to treatment certificates (T3) for individuals refusing, or who were unable to consent to medical treatment.

On the day we visited, 15 individuals were subject to the Mental Health Act across Coll and Barra Wards. All paperwork relating to their care and treatment was appropriately updated, including the use of T2 certificates for those who could consent to medications, as well as T3 certificates for those who would not or were unable to consent.

We were pleased to learn a process had been put in place for review and auditing of the Mental Health Act paperwork. The administrator now prompts the MDT to undertake reviews before expiry dates and the pharmacist reviews and audits all T2 and T3 paperwork. Monthly reports on reviews, expiry dates and use of T2 and T3 certificates are sent to ward and hospital managers; the pharmacist attends quarterly hospital meetings to discuss and address any issues.

Under the Adults with Incapacity (Scotland) Act 2000 (AWI), a section 47 certificate should be completed by a doctor where an adult is assessed to lack capacity regarding medical decisions. We met with one person who had been assessed to lack capacity relating to medical decisions, and found they were appropriately treated with a section 47 certificate.

Rights and restrictions

We were pleased to find that for individuals subject to detention under the Mental Health Act, they had been advised of their rights verbally and in writing, and that they understood this.

Many individuals accessed advocacy services. Since our last visit, access has continued remotely. Most individuals we met with told us that would prefer advocacy meetings to be in person. Managers advised they have agreed to provide the necessary health and safety training for advocacy workers to carry out face-to-face contact. It was reassuring to hear plans were progressing for advocacy visits and we look forward to hearing updates during our next visit.

Sections 274 and 276 of the Mental Health Act allows individuals to make an advance statement, which provides a legal safeguard for respecting decisions and preferences relating to their care and treatment. One individual in Coll and Barra Wards had an advance statement and we are pleased to hear that upon admission, everyone is offered support for this. We would advise that advance statements should continue to be offered and reviewed with individuals throughout their admission. The Commission has published information for individuals, nursing staff and hospital managers that may find helpful:
Advance Statements | Mental Welfare Commission for Scotland (mwcscot.org.uk)

Sections 281 to 286 of the Mental Health Act relate to specified persons, which is the appropriate legal safeguard when placing restrictions on an individual who is detained in hospital. Making someone a specified person should be the least restrictive option and where not doing so would place them, or others, at significant risk of harm. During our visit one person was found to be specified, with restrictions relating to use of their mobile phone. All documentation relating to this, including the reasoned opinion, were in place.

We were advised that Priory Healthcare have a service wide policy in relation to 'banned and restricted' items which includes restriction of smart phones to protect the privacy of all individuals. We were advised individuals on Coll, Barra and Tiree Wards are free to use, and keep their mobile phones in their own bedrooms but are requested not use in communal areas, such as the dining room. Those we met with had no concerns with this and felt able to contact their family freely and use their phones.

Individuals on Tiree were not subject to detention under the Mental Health Act and therefore could leave the ward, and hospital grounds, if they choose to do so. Many were accessing local community recovery, support, and activity groups. During this visit, individuals reported upon admission, they were advised to remain on the Tiree Ward and/or hospital grounds. Some individuals agreed, reporting this minimised risk of harm, such as when detoxing from substance and/or alcohol. However, others believed they were not permitted to leave the hospital advising us that "this is the way it is, "and "it's just part of being admitted." Most individuals were accessing the community following medical review within days of their admission. We did not see any recorded discussions regarding individuals being asked to remain on hospital grounds upon their admission to Tiree Ward.

We accept that for some individuals, remaining on the ward as part of recommended treatment may be appropriate, and lawful, as long they understand their rights, and are able to fully consent. However, the views expressed by some suggest this has not always been understood. We asked managers if restricting access out with hospital grounds was a blanket policy, for example applied to everyone, upon admission. We were advised individualised admission assessments are carried out with 'restrictions' to community access being applied where medically risk assessed, when the person agrees, and that this should be recorded in care plans. Ward managers advised us that the term 'restrictions' in this context is used to refer to situations where individuals are advised they should remain in the hospital grounds for medical reasons, such as detoxing from substances and being at risk of seizures. They reported the term 'restriction' may mislead some individuals into thinking they are not permitted to leave. We were told that managers will further review the information provided to patients verbally, and in writing, to ensure rights are clearly understood.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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

Recommendation 2:
Ward managers should ensure individuals on Tiree Ward are fully advised of their rights, verbally and in writing. They should check individuals understand their rights when being

asked to consent to recommended treatment, including being advised not to leave the ward/hospital.

Activity and occupation

Individuals on Coll and Barra Wards told us they enjoyed a range of leisure activities including trips to local parks, museums, cinemas, and coffee shops. Following on from our previous recommendation, we were pleased to hear these activities were available at weekends, with the introduction of an activity coordinator. Individuals on Tiree Ward were frequently accessing the local community, including local support groups.

During our last visit there was an extensive range of therapies available, and we were pleased to see that access to psychological and recreational therapies continue to be offered. Some individuals on Tiree Ward felt the availability of therapies over weekends was limited, which was fed back to managers on the day of our visit.

The environment

It was noted that bedrooms in Coll and Barra Wards were individualised. Some individuals in Coll and Tiree Wards reported issues with televisions not working, a carpet being stained and furniture looking 'chipped and tired'. We heard that whilst the quality of food was good, the choice of available snacks on Tiree Ward was limited to mainly cereal, with a lack of bowls in the snack area. These issues were fed back to ward and senior managers on the day. Ward managers acknowledged this and advised us that they were in the process of renewing items.

During our last visit we recommend that Tiree Ward ensured access for individuals with mobility issues and/or physical disabilities. We were advised of additional wet rooms being installed upstairs. Despite these developments, individuals who have any mobility issues or physical disabilities are only admitted downstairs for health and safety reasons, therefore cannot access these rooms. We continue to be concerned that the service may not be meeting its duties under the Disability Discrimination Act (1995). This will remain a recommendation requiring action.

Recommendation 3:
Managers should ensure that remedial work is undertaken as a priority to ensure that patients with mobility issues and/or physical disabilities are able to be safely looked after in Tiree Ward.

Any other comments

We heard comments from individuals and staff in relation to pressures on nursing and health care assistant staff. At times, these pressures reduced the staff availability to provide one-to-one support, which individuals valued in helping their recovery. Staffing pressures were acknowledged by senior managers, and we were pleased to see improvements in recruitment, retention, and development since our last visit. We noted that there has been improvement with this as nursing and therapy staff have returned to the service, and there are currently no registered nurse vacancies; agency staff have required to be used no more than twice in the last four months.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure consistent recording of person-centred goals and progress made.

Recommendation 2:
Ward managers should ensure individuals on Tiree Ward are fully advised of their rights, verbally and in writing. They should check individuals understand their rights when being asked to consent to recommended care and treatment, including being advised not to leave the ward/hospital.

Recommendation 3:
Managers should ensure that remedial work is undertaken as a priority to ensure that patients with mobility issues and / or physical disabilities are able to be safely looked after in Tiree Ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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