**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Portree Ward (IPCU) Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UZ

**Date of visit:** 30 July 2024

## Where we visited

Portree Ward is the intensive psychiatric care unit (IPCU) situated in McKinnon House at Stobhill Hospital. This is a 12-bedded unit for people aged 18-65 that provides intensive care, treatment and interventions to those who present with 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 individuals.

The ward continues to be a mixed-sex facility, providing three female beds and nine male beds, all single rooms with en-suite facilities. The function, facilities and layout of the ward remained unchanged since our previous visit in September 2023.

On the day of our visit there were 10 individuals in the ward with two vacant female beds.

When we last visited this service, we made one recommendation on the audit of care plans to reflect individual progress towards all stated care goals. The response we received from the service was that the charge nurses were ensuring weekly audits to address this recommendation.

On the day of this announced visit, we wanted to find out if, since our previous visit, managers had addressed the recommendation adequately. We also wanted to meet with patients and speak with their relatives, wherever possible. We wanted to review the progress of a number of individuals who had been in the IPCU longer than six months, and we wanted to hear from staff of their experience of caring for patients in the IPCU.

### Who we met with

We met with and reviewed the care and treatment of eight people. We also spoke with three relatives.

This local visit was undertaken using in-person meetings with individuals, ward staff and managers who were available on the day of the visit.

### Commission visitors

Justin McNicholl, social work officer

Douglas Seath, nursing officer

Gemma Maguire, social work officer

## What people told us and what we found

### Care, treatment, support and participation

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities available to them, their views on how their individual needs were being met, support with their cultural and spiritual needs and their views about the environment.

We were also keen to hear from individuals who had been in the IPCU for a number of months, and from those who were preparing to be transferred to another ward or hospital or discharged to the community.

Some of the individuals we spoke with were complimentary about the care they were receiving from nursing, occupational therapy and psychiatry staff. Individuals spoke of the staff being “friendly”, “helpful”, “caring” and “always around when you need them”. One individual stated, “everything is good here, I have no complaints” whilst another stated, “it’s better in the IPCU than in other wards I’ve been in”. We heard positive comments about the occupational therapy and activity staff from individuals who found the programme of therapies available “good” and “enjoyable”.

The majority of the people in the unit were confined to the IPCU due to their risks, the stage they were at in their recovery or legal status. We observed mostly positive interactions between staff and the individuals on the ward. However, we noted some harsh comments made by staff towards, and about, individuals; we discussed this with the managers after our visit. We also noted some judgemental language in the care records relating to individuals and we also highlighted this to managers to address.

On the day, we observed and heard from staff about the high numbers of individuals who were subject to direct observations by nursing staff. This tends to be a common occurrence in IPCU wards due to the level of distress or associated risks displayed by the patient group. We heard from managers that at over the last year, and their busiest times they had to provide direct observations for up to seven individuals. This has ranged from one-to-one observation up to four to one observation.

The Commission acknowledges that this intervention can place a significant demand on ward staff and the individuals being observed. During this visit, five individuals were subject to direct observations. We noted that these direct observations were delivered in a person-centred manner with regular reviews occurring by nursing staff, with the goal of seeking to reduce the observation levels were possible to minimise distress and focus on recovery.

We spoke with one individual who had been subject to general observations earlier in the year and who had still been able to harm themself. We have asked managers for a summary of these events to understand how this could have occurred in the ward.

Since our last visit, there has been a change in the psychiatric input to the ward. Previously there were two consultant psychiatrists who provided seven and five sessions respectively for the ward, with one of the psychiatrists having worked in the ward continuously for a number of years. During this visit, we were informed there was one lead psychiatrist covering the ward with a plan in place to recruit a new staff grade psychiatrist to supply additional sessions to the ward.

We heard from nursing staff that there remains a high ratio of staff to individuals. We were informed that the ward continues to use bank staff, as well as healthcare assistants to ensure that there is adequate cover for individual needs. We heard of plans to employ new nursing staff to the ward to address the current vacancies, with the goal of filling all nursing vacancies in the ward and across the hospital site. We look forward to hearing if the plans achieve the desired goal.

We heard of the support to the ward from the clinical psychologist who compiles case formulations to support staff. We reviewed and heard from staff about pharmacy staff input to the ward to ensure safe prescribing. We noted that there was a current shortage of the physiotherapy provision to the ward which managers aim to address in the coming weeks. We did not hear from any individuals that this reduction in staffing was affecting their care or recovery goals.

Following on from our last visit, we found that there remained good communication from medical staff to individuals on their goals and plans that would help them move on from the IPCU. All those that we met with, and who were well enough to engage with the Commission visitors advised us of the plans that were in place to move on to open wards, or back to the community.

The relatives we met with were mostly positively about the staff team and the benefits of the ward. There were comments that the staff were, “nice”, “okay” and were generally found to be welcoming when visiting the ward. We heard that it was easy to access the psychiatrist and to discuss their relative’s care, as and when required.

We heard some frustrations from the relatives about their family member being “stuck”, “inappropriately placed” and that they were “having to raise issues with my MSP… they are being left to rot”. These comments were also made by another individual who expressed their views around the lack of movement of their relative, from the ward to a more suitable specialist environment with appropriately trained staff with learning disabilities or acquired brain injury care experience.

We met with one relative who was not a named person, nor did they hold proxy powers. They expressed their unhappiness of being unable to influence the discharge planning for their family member. The Commission visitor signposted the relative to seek legal advice and to have further discussions with the psychiatrist.

All of the staff members we spoke with knew the individuals well and were able to comment on the care being delivered and the goals of the ward. This was further reflected in the interactions we observed and the daily notes we read. One student member of staff commented, “this has been a great placement, and I would like to work here in the future as there are so many opportunities to learn”.

Staff and managers acknowledged the positive impact of the teamwork in the ward, which has helped to maintain as far as possible, a calm and engaging environment.

We met with a few individuals who were subject to the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act). We heard about their frustrations at being unable to address their lengthy stays in the hospital and unpredictability of when they would ever be discharged. One individual had been in the ward for eight months, which appeared excessive as they were noted to be clinically safe for discharge however there were complex challenges for nursing staff and the individual navigating the court system and its associated processes. We are following up on this case.

**Recommendation 1:**
Managers should ensure that discharges are prioritised for those with who are inappropriately placed in the IPCU and require alternative specialist care.

## Care, treatment, support and participation

### Care records

Information on care and treatment was held on the electronic record system, EMIS and the electronic medication management system used by NHS Greater Glasgow and Clyde (NHS GGC).

The EMIS system record for each individual contained their detention paperwork, care plans, risk assessments, physical health monitoring, admission paperwork, contact details and information on their GP.

We found the majority of records on the electronic and the paper systems to be up-to-date. The information was easily accessible and provided a holistic picture of the individual care needs and progress.

The Clinical Risk Assessment Framework in Teams (CRAFT) included a review of the observation status. The management of risks in an IPCU is critical due to the level of restrictions faced by those individuals placed there. The CRAFT documents that we reviewed included individual risk management plans, were detailed and regularly updated.

There was evidence of the management of restricted patients.

We observed that the ward had a number of laptops available for nursing staff to use, in order to update records in ‘real time’.

Nursing care plans are a tool that identify detailed plans of nursing care, and effective care plans ensure consistency and continuity of care and treatment. Care plans should be regularly reviewed to provide a record of progress being made. During our last visit to the ward in 2023, we had concerns that this was not taking place. In particular, we found that they did not capture the progress that individuals had made during their time in the ward. We had recommended that all care plan reviews should capture the progress that individuals had made more accurately.

Since our last visit there has been work undertaken to introduce a new care plan template that records the care goals for each individual. This new template includes a review section. This change was commenced at the start of July 2024.

The care plans that we reviewed focused on mental health recovery, legal status, risks, history of violence and substance misuse. We found these new templates to be clear, with consistent recording and with set goals in place that reflected the individual's journey in the ward.

Once the care plans were completed, these forms were then uploaded to the document section of EMIS. As this is a new process, we could see that staff were still coming to terms with the changes. Despite this, we found this new process to be a significant improvement on the previous recordings in care plans. We look forward to seeing how this process influences the recording and goal setting of individuals care and treatment when we next visit.

**Multidisciplinary team (MDT)**

The IPCU had a limited multidisciplinary team, with nursing staff, the pharmacist, and the ward psychiatrist; the MDT meeting was held at least once a week in the ward. Occupational therapy, physiotherapy, psychology and other disciplines could provide written reports to the chair of the meeting when there was any progress but tended not to attend the meeting in person due to the demands on their roles. Referrals could be made by the MDT to all other services as and when required.

Individuals attended the MDT meeting at least once per week and used these meetings to obtain an update on their progress, changes to their care or treatment and where they could ask questions about their progress towards discharge. The ward had set timeslots each week for relatives to attend the meeting to ask questions of nursing or psychiatry staff; we received mostly positive feedback about the opportunities to attend these meeting. We were informed that the psychiatrist would offer to meet relatives out with these times, as and when required, to discuss progress or any further changes in care. This arrangement was reflected in the MDT notes that we reviewed.

The MDT meetings were well documented, with clear actions and outcomes recorded. The notes detailed the action plans that focused on how to support an individual's progression.

On the day of the visit, there was a newly recruited charge nurse to the ward. This meant that there were currently four charge nurse posts for the ward which helped to support individuals and new staff members to the ward. There were plans in place for this structure to be reduced to three charge nurse posts in the coming weeks.

We heard that the ward has a number of registered nursing staff vacancies, and this combined with staff absence has resulted in bank staff having to be used when there have been high levels of clinical activity or observations.

## Use of mental health and incapacity legislation

On the day of our visit, all ten of the individuals 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 (Criminal Procedure Act). The majority of the orders in place were under the Mental Health Act. We found that one individual's mental health paperwork had not been uploaded to the system. We highlighted this to staff and this gap in recording was amended.

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 examined the hospital electronic prescribing and medicines administration (HePMA) system that was in place across NHS GGC to assist nursing staff with the administration of all medication. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the prescribed medication.

Where individuals have granted a power of attorney (POA) or where there has been a guardianship order under the Adults with Incapacity (Scotland) 2000 Act (AWI Act), a copy of the powers granted should be held in the care records, and the proxy decision maker consulted appropriately. There were two individuals in the ward who lacked capacity and were subject to a welfare guardianship order and power of attorney. We did not find the respective paperwork for the powers in place.

**Recommendation 2:**
Managers must ensure all proxy decision making paperwork is recorded and stored in an individual's record.

We found two AWI Act section 47 certificates regarding capacity to consent to treatment, which had expired or were not in place.

**Recommendation 3:**
Managers must ensure that where appropriate, for all individuals who require a section 47 certificate under the AWI Act, these are recorded in the care record and in date.

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 an individual 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. On the day of our visit, there were two individuals who were subject to these procedures, and we were told that these arrangements are reviewed regularly to determine whether the restrictions in place are still required.

## 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.

We were told that individuals were provided with information about how to access independent advocacy and provided with contact telephone numbers for legal representation. Of the individuals we spoke to, they advised us of the ease of access to advocacy and praised this service.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they do or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit, we found that where advance statements had been made, this was noted in the individual's record.

When the Commission visits hospitals we are routinely provided with safety alarms to alert staff if we are or individuals need immediate assistance. During this visit we were informed that there were no safety alarms available for the Commission staff, which was a cause for concern. We were advised of the reason for this but there were actions that were required to address this gap in staff and visitor safety.

**Recommendation 4:**
Managers should seek to ensure there are safety alarms available for all visitors and staff to the ward.

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

## Activity and occupation

Activity and meaningful occupation, particularly in an IPCU, is important due to the level of restrictions individuals face. On the day of the visit, we visited the McKinnon House gym, kitchen and activities room that individuals can access if their level of restrictions has been reduced and they are assessed for these activities.

Those who were confined to the ward had access to playing pool, the ward gym, television, sports activities, video games and the opportunity to listen to music. We found evidence of additional activities created by the health care support worker and appointed therapeutic activity nurse (TAN) who had taken up post when we last visited the ward. It was positive to see the impact this role was having in providing meaningful activities for individuals. We found recordings of activities in the daily notes section of the care records.

Since the introduction of the smoking ban for the Stobhill Hospital site, the majority of individuals vape in the garden of the ward; we noted that this was supervised and monitored by nursing staff.

During this visit we observed individuals playing badminton, group video games and other recreational activities. The various social activities occurring on the day of the visit appeared to raise the morale of the patient group, bringing significant humour and joy to the day. One individual commented that the activity-based staff were, “brilliant, I would be so bored (without them) because with being restricted to the ward, there is little else to do”.

## The physical environment

The ward consists of 12 single en-suite bedrooms. There are three seating areas, a dining room, a de-escalation room, an activity room, a family room and a gym. The ward decor was bright and reasonably well-maintained.

We received no concerns or comments from individuals about the physical environment of the ward.

The Commission visitors noted issues with the removable bathroom doors. These doors were in place across NHS GGC and we have found issues with them in various wards; they can fall off their hinges easily if knocked or strongly pushed by individuals or staff. We found one individual where direct observations were in place and if using the toilet, due to the lack of bathroom door, his privacy and dignity was

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

compromised. We alerted managers to this issue and advised that steps should be taken to ensure that an individual's dignity should not be compromised even when subject to direct observations.

Due to the size of the ward, there remains limited storage for both individuals and staff. During our last visit we were advised that there were potential plans to remove the female bathroom in the ward and convert this into a storage facility to aid the layout and storage of various items. This plan did not proceed as there remains concerns about removing the only bath for the ward. We look forward to hearing how discussions on this issue have progressed when we next visit.

**Recommendation 5:**
Managers should ensure that all individuals' dignity is prioritised even when subject to direct observations.

## Any other comments

We received positive comments from individuals that their cultural and dietary needs being met while on the ward. They described the provision of halal menus, access to interpreters and quiet space for prayer. We did note issues with one individual not having a suitable interpreter. We noted the impact of this on the individual's journey through their recovery. This was not due to the actions of the ward staff but a wider issue regarding the interpreting service not having trained staff who specialise in the individual language.

**Recommendation 6:**
Managers should work with the interpreting services to meet language needs for all individuals in the ward.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that discharges are prioritised for those with who are inappropriately placed in the IPCU and require alternative specialist care.

**Recommendation 2:**
Managers must ensure all proxy decision making paperwork is recorded and stored in an individual's record.

**Recommendation 3:**
Managers must ensure that where appropriate, for all individuals who require a section 47 certificate under the AWI Act, these are recorded in the care record and in date.

**Recommendation 4:**
Managers should seek to ensure there are safety alarms available for all visitors and staff to the ward.

**Recommendation 5:**
Managers should ensure that all individuals' dignity is prioritised even when subject to direct observations.

**Recommendation 6:**
Managers should work with the interpreting services to meet language needs for all individuals in the ward.

## 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 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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