Mental Welfare Commission for Scotland

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

Date of visit : 20 March 2023

Where we visited

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 (aged 18-65 years) requiring intensive treatment and intervention who may 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.

The function, layout of the ward, and facilities were unchanged since our previous visit. The ward continued to be a mixed-sex facility. On the day of our visit, 10 of the 12 beds were occupied.

We last visited this service on 13 May 2021 and we made no recommendations.

On the day of this unannounced visit we wanted to meet with patients and if possible speak with their relatives. We also 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 six patients in the ward face-to-face.

We met with the inpatient psychiatrist, senior charge nurse, two deputy charge nurses and other nurses on the ward.

Commission visitors

Justin McNicholl, social work officer

Douglas Seath, nursing officer

What people told us and what we found

Care, treatment, support and participation

Our visit was, on this occasion unannounced, as a result patients, relatives, and staff were not prepared. Despite this, we were given full access to the ward to meet with patients and staff. The views of the patients that we spoke with were generally positive, with some stating they were "very pleased" with the nursing care and support provided by staff. One individual told us "the staff are very helpful and understanding; they are always trying to get you better". Something highlighted their frustration at being subject to significant restrictions of their liberty, "It's hell here, it's just about better than the jail. I just want to get out". It was clear that overall, patients generally felt the benefit of the care on offer to them, that aimed to ensure recovery was at the heart of the vast majority of care delivered.

We heard positive reports of the food supplied to patients, including the reasonable portions sizes and variety of meal options. We spoke to a number of patients who stated, "the food is great and there is a chance to get seconds if you are hungry, it is very good."

The ward had input from one consultant psychiatrist and one junior doctor with a specific remit for the ward. We heard from nursing staff that that there was 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 are more intensive. At the time of our visit, there was one patient on two-to-one observation whilst another patient was on one-to-one observations. Due to the level of increased observations in place and the number of nursing staff vacancies, the ward has to employ bank and agency staff, as well as lower grades of staff to ensure that there was cover for the ward. This was similar to our previous report when we noted vacancies throughout the hospital, including IPCU. Despite this, there appeared to be a consistency in the use of bank and agency staff who were providing the care that was keeping patients safe and supported in their care and treatment.

The main concerns that were brought to our attention related to those who found themselves subject to the Criminal Procedure (Scotland) Act 1995 ('the CPSA'). Patients expressed their frustrations in relation to being confined to the ward in line with restricted patient guidelines. These restrictions resulted in patients' behaviour escalating on the ward and the use of restraint techniques that were used to safely manage the stressed and distressed behaviours. Despite these levels of frustration, we found the ward to have a sense of calm on the day of our visit. Patients seemed comfortable in the company of staff and were happy to approach them. We observed a number of nurses supporting patients to identify and achieve their priorities for the day.

Care plans

Nursing care plans are a tool that identifies detailed plans of nursing care, and good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. During our visit, we saw a range of person-centred care plans that addressed both physical and mental health care needs. We did however find several care plans that required reviewing as it had been some time since these were last updated. The care plans that we read captured the complexities of the patients we met with and the care that was being provided to ensure their recovery. We recommended that all care

plans reviews were undertaken to ensure that a meaningful recording of patient progress was in place to capture the care we observed.

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 regularly audit care plans to ensure reviews are taking place on a consistent basis, that they are person-centred; include all the individual's needs and ensure individuals participate in the care plan reviews.

Risk assessments

We were pleased to see personalised risk assessment and management plans were in place. These recordings were easy to access with a clear rational for staff on what support achieved the best outcomes for the patients. We noted that there was one patient who was particularly vulnerable due to their level of needs. Under normal circumstances the patient in question 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 care.

Multidisciplinary team (MDT)

All patient care was reviewed at a weekly multidisciplinary team (MDT) meeting. On reviewing the MDT recordings, there was evidence of input from medical, nursing staff, with limited input from a variety of others disciplines due to staff issues across the service or the limited roles some professionals had when patients were acutely unwell. From the notes we reviewed, there was evidence of actions and outcomes clearly recorded in patients MDT forms, and documentation. There was evidence of input from psychology, as and when required, that aided the MDT. Physical health care was noted in the MDT, with screening evident.

System recording

There were two systems used for recording documentation. EMIS records electronically captured the majority of care, including daily notes, chronologies and MDT documentation. The rest of patient recordings were held in a paper file. As noted in our last report, this was not ideal as it separated the patient record. The goal for the service is for all information be accommodated on EMIS which would end the need for paper files.

Of the 10 patients on the ward at the time of our visit, the majority had been in for short periods of time, with clear plans for discharge. We viewed this as positive, as we would expect to see as many patients as possible spending short periods of time in IPCU. We consider that the ongoing long-term placement of patients in the IPCU ward is not satisfactory as it is not in-keeping with good patient care and treatment; we would hope to see this pattern of admissions continuing with our next visit.

Use of mental health and incapacity legislation

All patients in the IPCU were subject to detention either under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 ('the CPSA'). The patients we met with during our visit had a good understanding of

their detained status. All but one patient reported that they had advocacy support and legal representation.

All documentation relating to either the Mental Health Act or the CPSA, including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date. 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place, however we found a number where the medication prescribed did not match the T2 and T3 forms. We raised this with the psychiatrist at the time of the visit, and advised that this should be addressed as a matter of urgency.

Recommendation 2:
Managers should identify a system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given is legally authorised.

Any patient who receives treatment under the Mental Health Act or Criminal Procedures Act (where applicable) can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Rights and restrictions

This IPCU is a locked ward and has a 'locked door policy' that is proportionate to 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 from enhanced observation of nursing staff. We were told that patients who were subject to enhanced observations were reviewed daily. The clinical team discussed the patients' care and treatment to determine whether the observation level could be safely reduced. Patients were encouraged to participate in their safety plan and this was recorded in their files.

We noted on occasion, staff were required to use seclusion when caring for an individual. We noted that this was taking place in patients' bedrooms. This use of seclusion was problematic for patients, especially those who had to spend prolonged periods of time in their bedrooms and who were also subject to observations. Staff and management acknowledged that for all patients this was not best practice and steps were being taken to move any patients, who were under these circumstances, to a more suitable setting. Despite this, we found good evidence of the recording on the use of seclusion, and the levels of observation applied in relation to patients' care.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained 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 to be regularly reviewed. Where a person has been made a specified person, they should be given clear information about this and made fully aware of their right to ask for review of this status.

On our visit, there were patients who had been made specified persons; from reviewing their files, we found clear evidence that the relevant paperwork in place.

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

On the day of the visit, there was limited activity taking place in the IPCU despite there being enough staff available to facilitate this. We did note that there were opportunities for nurses to work with patients on fitness programmes in the ward gym, crafts and other recreational activities. We were unable to find evidence of participation in activity in continuation notes, although it was noted that due to the mental ill health of some patients, this was not always feasible. We found some individualised activity planners tailored to the patient's preferences. We discussed the issue of activities with managers of the ward and it was acknowledged that activity has suffered primarily due to the limited amount of activity provision for the ward. We were informed that managers of the service had to make bids to obtain activities for patients. This included short-term input to the ward in the form of art and music sessions supplied by external artists. These opportunities were viewed favourably by the patients, with them telling us that these were "enjoyable" and "a great outlet". We believe there should be consistent plans to ensure activities for patients and the use of dedicated staff and funding would likely be the best means to achieve this.

There was evidence of physiotherapy input to the ward and we were informed that the occupational therapist (OT) provided a comprehensive functional assessment of needs, with care plans that were person-centred and regularly reviewed and updated. Furthermore, there is a plan to employ a further part time OT. We look forward to seeing their input during our next visit.

Recommendation 3:
Managers should ensure that the IPCU receives dedicated activity provision commensurate with that provided to other wards on the hospital site.

The physical environment

This ward was purpose-built and was light, spacious, well decorated and well maintained. The ward consisted of 12 single en-suite bedrooms and a large communal seating area with an additional quiet sitting room. There was an activity room, a gym with a variety of exercise equipment and meeting rooms that could be used for family visits. Access to the gym was given on completion of a screening form to ensure patients could be signed off for unsupervised sessions. Once this was completed, patients could fully participate in their exercise goals.

There was an enclosed garden that patients could access directly from the communal areas of the unit and this was utilised regularly to allow patients fresh air and if required, to smoke.

Those that we spoke with on the day of the visit raised the topic of the pool table with us. This had been damaged, with tears observed across the surface that made it difficult to play on. We were informed that the table was being repaired in the coming week. We look forward to seeing this improvement during our next visit.

Visiting following the Covid-19 pandemic is once again face-to-face for all patients and was facilitated to meet the patient's, and wherever possibly the family's needs. The staff team endeavoured to ensure they there was regular contact with families and risk assessed how to manage patient contacts with their relatives as on occasion this could be challenging due to level of illness for some patients.

Summary of recommendations

Recommendation 1:
Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that they are person-centred; include all the individual's needs and ensure individuals participate in the care plan reviews.

Recommendation 2:
Managers should identify a system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given is legally authorised.

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Managers should ensure that the IPCU receives dedicated activity provision commensurate with that provided to other wards on the hospital site.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk