Mental Welfare Commission for Scotland

Report on unannounced visit to:

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

Date of visit: 11 September 2023

Where we visited

Portree is the intensive psychiatric care unit (IPCU) situated in McKinnon House at Stobhill Hospital. This is a 12-bedded unit for individuals aged 18-65 that provides intensive care, treatment and interventions to 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. The ward continues to be a mixed-sex facility, split as maximum of three female beds and nine male beds that are all provided with single en-suite rooms. The function, layout of the ward, and facilities are unchanged since our previous visit in September 2022. On the day of our visit there were three vacant beds.

When we last visited this service, we made seven recommendations regarding the need to address patients understanding of their suitability for IPCU care and treatment, that there should be patient participation in care planning, that any young people in the IPCU should be able access education and that all relevant parties were able to attend multi-disciplinary team meetings (MDT). We recommended that advocacy should be easily accessible, that there was staff training on the promotion of advance statements and that maintenance of the ward was required to ensure that it provided a conducive setting for patients.

The response we received from the service was that all of these recommendations had been prioritised and addressed.

On the day of this unannounced visit we wanted to find out if, since our previous visit, managers had addressed the recommendations adequately and that the action plan was having a direct impact upon patients' experiences on the ward. Due to the unannounced nature of this visit it was not possible to speak with relatives, however we took into consideration any contact relatives and individuals had made with the Commission since our last visit. These communications have helped to inform the themes we focused on during the visit.

Who we met with

We met with, and reviewed the care and treatment of five patients.

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

Commission visitors

Justin McNicholl, social work officer
Mary Leroy, nursing officer
Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

As our visit was unannounced, those individuals on the ward, relatives, and ward staff were not prepared for our visit. Despite this, we were given full access to the ward in order to meet with patients and staff. The majority of individuals that we spoke with were satisfied with the care and support provided by nursing and allied health professionals (AHPs).

Those that we spoke with, who were positive in their views of staff, told us “they are brilliant”, “fantastic” and “they help me feel safe”. Patients described how when they were unwell, the staff took various steps to provide reassurance to address their level of distress. It was clear from observations, and individual reports from patients, that they trusted the staff and that personalised care was being delivered. We noted that some individuals had been in the ward for prolonged periods of time due to their illness; despite this, it was evident that staff were continuing to seek ways to provide care in a person-centred manner.

We heard some positive comments from those that we spoke with about the food supplied to the ward. One described it as “excellent”. We were advised of the community meetings which take place in the ward provides individuals with the opportunity to express their views about any matters that are affecting them during their stay in the IPCU.

Since our last visit, there has been a change in the psychiatric input to the ward. Previously there was one lead psychiatrist with an additional staff grade psychiatrist in place. There are now two consultant psychiatrists who provide seven and five sessions respectively for the ward, with one of the psychiatrists having worked in the ward continuously for a number of years.

We heard from nursing staff that there remains a high ratio of staff to patients. Routinely there should be seven members of staff on shift, however on the day of our visit this had been reduced to six. This reduction was not uncommon and tended to depend upon the demands across the hospital site; staff are moved to assist in other wards who may have vacancies or sickness on any particular day. Staffing provision in an IPCU is particularly important due to the increased levels of clinical risk and complex needs of the patients. We were informed that the ward will use bank staff, as well as healthcare assistants to ensure there is adequate cover for the ward. We heard of plans to employ new nursing staff to the ward to address the current vacancies.

We heard of the support to the ward, from both the clinical psychologist and pharmacy staff, which helped to ensure compliance with safe prescribing as well as psychological formulation discussions that has supported the provision of care and behavioural strategies, to those who were most unwell in the ward.

Since our last visit, we found that there had been a significant improvement in the level of communication from medical staff to patients, on what was expected from them in order to move on from the IPCU. All those that we met with, and who were well enough to engage, advised us of the clear plans that were in place to move on to open wards or back to the community.

We were not able to speak with relatives as the visit was unannounced, however were able to note the improvements taken to ensure that weekly multidisciplinary team meetings (MDTs) had dedicated sessions for named persons, friends or relatives of patients, so that they could attend and meet with the lead clinician. The staff advised us that this has helped to improve communication and resolve any questions relatives have had about their relative's care and about future plans.

All of the staff members we spoke with knew the patients 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 member of staff commented, "this was my first post since qualifying and the support of the team in this ward is brilliant. I have no regrets about working here, everyone is approachable and supportive". Staff praised the team working on the ward, which has helped to maintain consistent care for the patient group.

We were pleased to see personalised risk assessment and management plans, with a clear chronology of significant events during a patients' journeys through the ward. These records were easy to access, with clear rationale on what support achieved the best outcomes for the individual.

During our last visit to the ward, we had concerns regarding the repetitive and generalised nature of the care plans. In particular, we found that they did not capture the complexities of the individuals, and the care that was being delivered. At that time, we had recommended that all care plans were reviewed to ensure a more personalised and meaningful record. Positively, during this visit we found significant improvements in the care planning reviews recorded in the patient notes. We found these to be detailed, meaningful, personalised and linked directly to the progress of the individual over the weeks or months they were in the IPCU.

It was positive to note this progress and the consistency in the care plan review system. We did however find gaps in the original care plans that were generated when patients were first admitted to the ward. These care plans are kept in paper notes and some that had no signatures from either the staff or patients. Whilst others did note that some patients were not able to sign the care plans, due to how acutely unwell they were at the time of them being created. We found that some minor amendments were required to care plans, to reflect changes in mental health act legislation, due to the lengthy of time the individual had been in the ward. Senior managers agreed to address these discrepancies and find a means to ensure that the care plan reviews would also be captured in the original care plans.

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 plans to ensure they fully reflect the patients' progress towards stated care goals.

Care records

Information on patients' care and treatment was held in two ways. There was an electronic record system EMIS, the electronic health record management system used by NHS Greater Glasgow and Clyde (NHSGGC), and the ward also used a paper file for all patients; this contained the detention paperwork for the individual and other information for quick reference, such as care plans, admission paperwork, contact details and information on the patients' GPs. There is a long-term plan in NHSGCC for all patient records to be held on EMIS but there is no exact date confirmed for this as yet.

We found the majority of records on the electronic and paper systems up-to-date. We observed that the ward had a number of laptops available for nursing staff to use, in order to update records in 'real time'.

Use of mental health and incapacity legislation

On the day of our visit, all nine 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 to view.

All documentation relating to the Mental Health Act, the CPSA and Adults with Incapacity (Scotland) Act 200 (the AWI Act), 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 where required, and corresponded to the medication being prescribed.

We examined the Hospital Electronic Prescribing and Medicines Administration (HEPMA) system which is in place across NHSGGC to assist nursing staff with the administration of all medication. We found T2 and T3 forms were keep in paper files which then cross referenced by nursing staff to ensure that they were consistent with the medication prescribed on the HEPMA system. We found some minor issues with two T3 forms that needed to be amended to reflect the current treatment. The rest of the forms that we reviewed were completed by the responsible medical officers (RMO) to record consent, and were found to be up-to-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 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. On the day of our visit, there were three patients 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.

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 the visit there was one patient who was subject to one-to-one observations and was being supported in the de-escalation room. We were advised that enhanced observations were reviewed daily by the medical and nursing team. We reviewed this, and were pleased to find that the care that was being delivered was to a satisfactory standard.

We were told that patients are provided with information about how to access independent advocacy and provided with contact telephone numbers for legal representation. During our last visit we spoke with individuals who had not been referred to an advocacy service, and did not have an allocated social work Mental Health Officer. We had previously made a recommendation about this matter, and found this to have improved for this visit. It was noted that staff actively encouraged patients to access advocacy services, who were assisting them with their right of appeal or that advocacy was available to support individuals in relation to their legal status. Senior managers advised us that meetings had taken place with advocacy services in the last year to progress our recommendation, and this is now working well to ensure that patient's rights were utilised.

When we are reviewing patient files we looked 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 want or do not want. Health boards have a responsibility for promoting advance statements. Previously we found a lack of awareness about advance statements, and a strategy was put in place to ensure these were promoted. On the day of the visit, we found that where advance statements had been made this was noted in the patient's record. Senior managers advised us of the steps they continue to take with advocacy to ensure that patients can complete advance statements whenever they are in a position to do so. Staff in the ward are able to refer patients to advocacy, who then meet with the patient to discuss the completion of any forms.

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

Activity and meaningful occupation, particularly in an IPCU, is important due to the level of restrictions patients face. On the day of the visit, we had sight of some activities that were happening in the ward including playing pool, accessing the gym, watching the ward television and the opportunity to listen to music. We found evidence of weekly timetabled activities created by the health care support worker. We were informed that the ward was about to have a newly appointed therapeutic activity nurse (TAN) taking up post on the ward. We look forward to hearing more about the impact of this role with those individuals on the ward at our next visit.

Despite the current TAN provision in the ward, there were opportunities for patients to have time out to access the Hospital rendezvous tearoom, which is on the Stobhill site. We were informed that the ward has a music group, as well table tennis for patients. Since our last visit, we noted that there was improved access to the gym, and this was being utilised more readily, as were the gardening activities in the ward garden. We found clear recording of activities in the patient continuation notes.

We discussed the implications of the newly agreed smoking ban for the Stobhill site. The IPCU no longer allows patients to smoke in the garden area of the ward and various smoking cessation strategies have been introduced to support patients through this transition. We found that most patients had transitioned from smoking cigarettes to vaping in the ward garden.

We were advised of the lack of support to the ward by occupational therapy staff. We were told that this was being addressed by senior managers across the hospital site and when we next visit we will look to have an update on this matter. We did not hear from any patients that this lack of staffing resource was directly impacting upon their recovery planning. We were advised that input from physiotherapy and dietetic staff was made by referral and there were no current barriers to accessing these services. Patients spoke positively of having time out of the ward to attend the local shops or to spend time with their families.

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 gym. The ward decor was bright and reasonably well-maintained. During our visit in 2019, we made a recommendation regarding the condition of the de-escalation room; in 2022, this had been addressed with new flooring and improved décor. The flooring has been replaced again in the last year and a new large bean bag has been purchased to minimise the use of hands-on restraint for patients in the de-escalation room. We observed new high back chairs that had been purchase for the ward to avoid any neck injuries.

Since the last visit, there was a notable improvement with the heating system now working correctly in the ward. This has helped to avoid patients sleeping in their clothes as we noted during the last visit.

One of the bedrooms on the ward was out of commission as the toilet was cracked and there were plans in place to repair this. We noted that one of the windows in the seating area had been damaged by one of the gardeners and this had been alerted to estates to repair.

Due to the size of the ward, there was limited storage for both patients and staff. 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. We look forward to finding out how this progresses at our next visit.

Any other comments

We were advised by senior managers that there is work required to the fabric of the ward if it is to regain their previous AIMS accreditation. AIMS is a programme designed to assure staff,

patients and carers about the quality of inpatient services by ensuring that wards units are complying with a set of standards that reflect issues which make a positive and tangible difference to patient experience. When we next visit we look forward to hearing if this accreditation has been achieved.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plans to ensure they fully reflect the patients' progress towards stated care goals.

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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