Mental Welfare Commission for Scotland

Report on announced visit to:

Intensive Psychiatric Care Unit (IPCU), Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 12 March 2024

Where we visited

The Intensive Psychiatric Care unit (IPCU) is a 12-bedded, mixed-sex, 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. On the day of our visit, 11 of the 12 beds were occupied.

We last visited this service in March 2023 and we made three recommendations. These were the need to audit care plans and consent to treatment forms, and ensuring dedicated activity provision for the ward. The response we received from the service was that managers were addressing the recommendations and had an action plan in place, working towards completion.

On the day of this announced visit, we wanted to meet with individuals and speak with their relatives. We wanted to check progress on the number of individuals who found themselves in the IPCU longer than 6 months and we wanted to hear from staff about their experience of caring for individuals in the IPCU.

Who we met with

We met with and reviewed the care of seven people. We also spoke with four relatives.

We met with the service manager, senior charge nurse, deputy charge nurses, senior occupational therapist, music therapist, consultant psychiatrist, and nursing staff throughout the day.

Commission visitors

Justin McNicholl, social work officer

Kathleen Taylor, engagement and participation officer

Margo Fyfe, senior manager

What people told us and what we found

As this visit was announced, individuals, their relatives and staff were prepared to meet with Commission visitors. 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 and views about the environment. We were also keen to hear from individuals who had been in the IPCU for many months and those who were preparing for transfer to another ward, discharge to the community or returning to prison.

The majority 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 "lovely", "they have treated me brilliantly", "they communicate well", and "I'm well cared for here". We received positive comments about the occupational therapy staff and activity staff from individuals who found the programme of therapies available "decent", "really very helpful", and "focused on trying to get you better".

All of the individuals we spoke with praised the work of the Nordoff and Robbins music therapist who visits the ward once per week to provide therapy. They stated, "she is absolutely brilliant", "I get to sing and meditate on music" and "I really enjoy spending time with her". We were able to observe the work of the music therapist with each individual's consent. All of the work undertaken was person-centred and benefitted those who engaged in the therapy.

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, "approachable" and "lovely" and were generally found to be welcoming. There was positive praise for the ease of access to the psychiatrist and being able to meet to discuss their relative's care, as and when required. One relative commented that their family member had, "come on leaps and bounds" thanks to the staff and that they felt "respected" at all times by the staff. We heard from one relative who was unhappy about the care their relative had received and we discussed this with the staff on the day. The staff advised that they were planning to address this relative's experience by reviewing the concerns and learning from their experience.

We heard from nursing staff that that there was a high ratio of staff to individuals; this is particularly important in an IPCU ward where there are increased levels of clinical risk, and individuals' needs are more intensive. At the time of our visit, there was one individual who was on enhanced observations. This was a reduction in the number of individuals who were on observation levels as compared to our last visit; the ward environment appeared to be a calmer. The ward has to employ bank and agency staff to aid with observation levels, which is consistent with what takes place across other hospital wards.

We met with a number individuals who found themselves subject to the Criminal Procedure (Scotland) Act 1995 (the Criminal Procedure Act). Compared to our last visit there was significant improvement in the level of understanding from those who are confined to the ward in line with restricted patient guidelines. We observed that individuals appeared comfortable in the company of staff and peers. We observed a number of nurses supporting individuals to identify and achieve their priorities for the day.

Care, treatment, support and participation

Care records

Information on care and treatment is held in three ways; there is a paper file, the electronic record system EMIS and the electronic medication management system used by NHS Greater Glasgow and Clyde (NHS GGC).

The ward has a paper file for each individual that contains their detention paperwork, care plans, admission paperwork, contact details, and information on their GP. There is a long-term plan in NHS GCC for each individual's records to be held on EMIS, but there is no exact date confirmed for this to occur in the IPCU. We look forward to hearing how this will be implemented for the ward and how staff and individuals adjust to this transition in due course.

We found all records on the electronic and paper systems up-to-date. The majority of the information was easily accessible and provided a holistic picture of individuals' care needs and progress. The management of risks in the IPCU is critical due to the level of restrictions faced by those individuals placed there. The CRAFT risk assessments we read were detailed, regularly reviewed, and we saw clear individual risk management plans included in the records. There was clear 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 identifies 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.

We were pleased to find that the care plans for this visit were detailed, dated correctly, meaningful, person-centred and linked directly to the risks and restrictions of an IPCU. We were able to gather a sense of each individual's mental and physical health that related to the reasons for their admission to the IPCU. All care plans are kept in paper notes. The recording of individuals' care plan reviews for the ward were recorded on the ward's 72 hour initial assessment forms. These forms are used at the point of admission and are completed by staff to record the care that individuals received from a nursing perspective. We found the use of the initial assessment form was confusing for the Commission staff, as it took considerable time to locate and identify how individuals were progressing and how this related to care plan reviews. Due to this confusion we believe that the specific recording forms for care plan reviews should be clearly labelled and filed appropriately alongside the care plans in individual records.

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 ensure that the recording of care plan reviews are appropriately recorded and filed alongside individuals' care plans.

Multidisciplinary team (MDT)

The IPCU has a limited multidisciplinary team, pharmacy staff, nursing staff, and the ward psychiatrist; the meeting is held at least once a week in the dining room of the ward. Occupational therapy, physiotherapy, psychology, and music therapy staff provide written reports to the chair on any progress, but tend not to attend the meeting in person due to the demands on their roles. Currently there is a new psychologist appointed to the ward who is due to take up post in the coming month. The appointment of this role will provide more consistent input to the ward and MDT meetings. Referrals can be made by the MDT to all other services as and when required.

Individuals attend the MDT meeting at least once per week and use these meetings to obtain an update on their progress, changes to their care or treatment, and where they can ask questions about their progress towards discharge from the ward. Relatives can 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 individuals on a second occasion at the end of the week if required, to review their progress and discuss any further changes to their 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 clear action plans that focused on how to support an individual's progression on from the ward, with clear scenario planning in place. In some of the meeting notes we reviewed, we could not find the title of the professionals in attendance; however due to the low numbers it was clear who attended. The chair of the MDT meetings agreed to address this gap in recording, which would ensure that all titles of the professionals in attendance would be listed.

There was an additional deputy charge nurse post created in August 2023 to aid with the structure of the ward. This means there are three deputy charge nurse posts for the ward which helps to support individuals and new staff members to the ward. There remains some recruitment challenges for the ward. We heard that the ward has a number of registered nursing staff vacancies, and this combined with staff absence results in bank staff having to be utilised when there are high levels of clinical activity or observations.

Use of mental health and incapacity legislation

On the day of our visit, all 11 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 Act). Most of the paperwork that was in place was under the Mental Health Act. The appropriate detention paperwork was readily available.

We heard directly from individuals that they were aware of their rights in relation to the orders to which they were subject. This included easy access to advocacy, with information displayed on a poster at the entrance to the ward. Many of the individuals we spoke to had

input from a solicitor to represent them at previous or forthcoming mental health tribunal hearings, including any appeal hearings.

All documentation relating to the Mental Health Act, the Criminal Procedure Act and Adults with Incapacity (Scotland) Act 2000 (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 that is in place across NHS GGC, to assist all nursing staff with the administration of all medication. There was consistency in relation to how the information on the T2 and T3 forms corresponded to the medication prescribed on HEPMA. The forms that we reviewed were completed by the responsible medical officers (RMO) to record consent, which were found to be up-to-date, or in the process of being completed by a visiting approved medical practitioner.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Individuals spoke of nominating named persons to aid them whilst subject to the Acts. Upon reviewing individual records, we found clear documentation regarding these nominations and acceptance of these roles by their friends or relatives.

Rights and restrictions

The 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 was one individual who required additional support from enhanced observation through continuous intervention with the nursing staff. We were told that the individual who was subject to this was reviewed daily.

When we last visited the ward, we found that staff were required to use seclusion when caring for an individual. We noted that this was taking place in the individual's bedroom, which was not ideal. There was no use of seclusion taking place during this visit and staff advised that there had been no use of seclusion in a considerable period of time. During our tour of the ward, we were able to visit the extra care area of the ward, which is a space designed to nurse individuals away from the noise of the rest of the ward. This was not in use although staff noted that it was a helpful resource to have when managing individuals who were struggling with their mental health. We visited the de-escalation room in the ward that could be used for those who are experiencing periods of stress and distress. This also was not in use. We asked for, and were provided with, the policy and operational procedure for the use of these areas.

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 three individuals who had been made specified persons; from reviewing their files, we found clear evidence that the relevant paperwork in place with reasoned opinions recorded.

Managers should keep under review MDT training in the application and use of specified persons. Our specified persons good practice guidance is available on our website: https://www.mwcscot.org.uk/node/512

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 want or do not want. Health boards have a responsibility for promoting advance statements. We found no advance statements, which is not uncommon for IPCUs that have some of the most unwell individuals. Despite this, we found evidence of the promotion of advance statements at the reception area of the ward, with leaflets available to explain to individuals their rights.

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

Activity and occupation

On the day of the visit, there were a number of activities taking place in the IPCU including input from the Nordoff and Robbins music therapist, who visits the ward once per week. The music therapist completes a comprehensive summary of the activities undertaken with individuals and we were able to access these recordings on the day of our visit.

We noted that there were opportunities for nurses to work with individuals on crafts, talking groups, playing pool, board games, computer games, and other recreational activities. The ward holds theme nights to keep individuals stimulated; these include movie nights. We were able to find evidence of participation in activities in individual continuation notes. We found personalised activity planners, tailored to individual preferences. We found a weekly activity chart on display at the reception area of the ward. We were pleased to see the high level of activities available on the ward, which is a significant improvement compared to our last unannounced visit when we heard that activities were not comparable to other wards in the hospital. We heard that there were some gaps in the availability of activities at the weekend due to the current working pattern of the ward staff. Despite this, we heard of the steps that nursing staff have taken to address this gap and to ensure that individuals are kept busy and offered opportunities to engage in meaningful social activities.

The relatives and individuals we spoke with praised the opportunities available in the ward and the work undertaken by staff to help them with their recovery. Individuals spoke of the benefits of the ward therapeutic activity programme and the visit by various external groups.

The physical environment

This ward is purpose-built and is light, spacious, well decorated, and well maintained. The ward consists of 12 single en-suite bedrooms, an additional extra care area, de-escalation room, and a large communal seating area with an additional quiet sitting room. The bedrooms were found to be maintained to a high standard with no concerns raised regarding these living spaces. 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 are two enclosed gardens. One which people can access directly from the communal areas of the ward and this was utilised regularly to allow patients fresh air and if required, to smoke. We note that there has been a change in the law prohibiting smoking on hospital grounds and there is still progress being made to address this transition. The second garden is quieter and can be used by those individuals who benefit from a degree of privacy and who may struggle in larger groups or outside spaces.

When we last visited the ward, we spoke with individuals who told us that the pool table had been damaged. It was positive to note that this had been repaired and was in full working order.

From what we heard, the staff team endeavour to ensure that there is regular contact with families. Individuals' contact with their family is risk assessed, and this can be challenging due to level of illness for some individuals. We observed relatives visiting the ward and this was managed safely and respectfully for all involved.

During our visit, we found evidence that the work of the Commission was promoted at the reception to the ward, with copies of our guidance, which included explaining our role and links to our good practice guidance.

Summary of recommendations

Recommendation 1:
Managers should ensure nurses are provided with the appropriate forms to record care plan reviews on which identify the progress of each person, setting out clearly the interventions and support required for the individual and that these are filed alongside to the care plans.

Good practice

We were pleased to see relatives being given the opportunity to have their voices heard and views expressed. This included a questionnaire being supplied to engage meaningfully with relatives about what works best for the individual in the care of the ward. From these questionnaires we found clear evidence on display at the reception area of the ward of the feedback achieved from relatives and carers to help inform practices and experiences. The Commission's view was that this as a very positive step that we do not routinely see in other wards and IPCUs. We hope this level of engagement could be adopted by other wards to improve the experiences of relatives and carers.

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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