

Mental Welfare Commission for Scotland

Report on an unannounced visit to: Gartnavel Royal Hospital,
Intensive Psychiatric Care Unit (IPCU), 1005 Great Western
Road, Glasgow G12 0XH

Date of visit: 6 February 2017

Where we visited

The Intensive Psychiatric Care Unit (IPCU) is a 12-bedded, purpose built facility in Gartnavel Royal Hospital. The unit can admit both male and female patients. On the day of our visit there were 12 patients, all of whom were detained under either the Mental Health Act (MHA) or the mental health provisions of the Criminal Procedures Act (CPSA). We last visited this service during our series of announced and unannounced visits to all IPCUs in Scotland in 2015.

On the day of our visit we wanted to follow up on our previous feedback and recommendations from the last local visit. These were:

1. Managers should ensure there is an audit system in place to ensure mental health forms are present in the ward and consent to treatment documentation (T2) and forms authorising treatment (T3) are up to date and located with the medication kardex.
- 2 .Consideration should be given providing artwork in corridor areas to make them less clinical in appearance.

Who we met with

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

We spoke with the charge nurse and also the staff nurse on duty.

Commission visitors

Mary Leroy, Nursing Officer

Mary Hattie, Nursing Officer

Kathleen Taylor, Engagement and Participation Officer (Carer)

What people told us and what we found

Care, treatment, support and participation

All the interactions towards patients we observed from staff were friendly and supportive. We heard positive comments about staff from some patients we met. Staff were knowledgeable about the patients when we discussed their care. This was also reflected through care plans that were person-centred, containing individualised information, addressing the care needs of each person, and identifying clear interventions and care goals.

All care plans had a summative evaluation indicating the effectiveness of the interventions being carried out and any changes needed. Patient participation in care planning was evidenced in the care plan and through chronological patient notes. We also saw documentation of one to one sessions with nursing staff in patients' notes.

We noted that Glasgow risk assessment and management plans were detailed and personalised with clear interventions to manage risk and were evaluated and reviewed regularly.

Multidisciplinary team (MDT) input

We saw good assessments undertaken by staff on admission, including completion of the Glasgow risk assessment and management pro-forma. Stickers recording individual episodes of use of 'if required' psychotropic medication, were used within the daily notes and easy to find.

The documentation for the MDT meeting record included reason for referral/expectation of stay, key worker summary, risk, medication, observation levels, time out, legal status, therapeutic activity programme, summary of progress, physical investigation, specified person, named person views, progress on ward, mental state and a clear multidisciplinary action plan. We found that both medical and nursing staff had completed this documentation to a high standard; this system documented comprehensive weekly MDT reviews.

The MDT review meeting is held weekly and is attended by nursing staff and a consultant psychiatrist. Other staff attend on an individual basis (e.g. mental health officer (MHO) and staff from host ward).

Engagement with carers and relative

On the day we visited on an unannounced basis and we were unable to meet with family/carers. The charge nurse told us that families/carers can phone nursing staff for updates at any time. They are also informed that they can make appointments with the consultant psychiatrist.

The weekly MDT review includes a section for engagement with carers and relatives. On admission, staff contact family and carer asking them to complete a carers' questionnaire. This gives information about the patient and his/her presentation from the carer's perspective. There is also a chronological sheet that records carer contact. There is good evidence of patients being actively encouraged to think about family contact and whether they want information shared. Those conversations are recorded into the patient notes. The staff team appear to have embedded into practice many processes that augment good communication with carers and relatives.

Rights and restrictions

Advocacy

Patients appeared well supported by individual patient advocates from The Advocacy Project. We saw evidence of this through the patient notes and also through comments made by patients during individual interview.

Restraint and seclusion

The charge nurse informed us that all staff have completed the violence reduction programme. This is delivered on a rolling programme basis with staff attending annual updates.

We asked about the use of restraint in the ward and were informed that this is avoided where possible. If restraint is required it is for a minimum time. Staff are trained in de-escalation techniques and specific techniques are recorded in the supporting care plan.

Debriefing after restraint

The patient safety plan recognises the benefits of positive risk taking as part of the recovery journey. This plan documents the rationale using a standardised process for the assessment and monitoring of risk. The patient safety plans are reviewed daily and updated when there is a significant event. The plans are developed collaboratively and signed by the patient. The patient safety plan also informs and guides the debriefing process.

At present the staff are developing the patient safety plan but comment that in practice patients are reluctant to participate in completing this documentation. The team are continuing to try and embed this into daily practice.

Use of mental health and incapacity legislation

We examined the drug prescription sheet and noted treatment certificates (T2/3) were in place for all patients who required them. MHA paperwork and copies of all relevant documentation were within the patient file as appropriate.

Specified persons

Two of the patients we met had been made a 'specified person', one for safety and security and the other for telephone use. Each of the individuals had a supporting care plan which included all necessary documentation.

The IPCU has a locked entry to the ward so all patients and visitors are unable to gain access or leave the unit without staff opening the door. Patients have access to an enclosed garden that can be directly accessed from the ward.

Activity and occupation

We saw comprehensive occupational therapy (OT) assessments of the individuals' needs, strength, limitations and identifying areas to develop. OT undertake individual and some group activities, they also provide kitchen assessments.

The patient activity coordinator nurses also provide a range of group activities within the ward. Patients can access an activity room with facilities for art and games and a snooker table. There is also a small gym patients can access.

Nursing staff also support individuals with activities. We were advised by the charge nurse that nursing staff are taking a more active role in engaging patients in activities. During interviews with patients, they discussed some of the activities they had participated in and this information was also documented in the patient notes.

The physical environment

The unit is purpose built; it is light and spacious, well decorated and maintained. The unit consists of 12 single en-suite rooms, a large seating area, plus one other smaller sitting area, dining room, well equipped activity room and a small gym.

There is access to a well planted garden area. Outside the ward area, there is a room that can be used for family visits.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Alison Thomson

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 MWC 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

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

