Mental Welfare Commission for Scotland

Report on unannounced visit to: The Priory Hospital Glasgow, 38-40 Mansionhouse Road, Glasgow, G41 3DW

Date of visit: 26 October 2016

Where we visited

The Priory Hospital Glasgow is a private, 42-bed psychiatric hospital. The hospital currently has two units: a 25-bed eating disorder facility for women, and a second unit providing inpatient care for patients with a range of medical disorders including depression, psychotic illness and substance misuse. We last visited the eating disorder unit on 25 November 2015 and made recommendations regarding:

- Care plans
- Risk assessment
- Use of the Mental Health Act (MHA) and advocacy
- Training

On this visit we wanted to follow up on the previous recommendations. We also wanted to look in more detail at the experiences of patients from outside Scotland who are receiving treatment at the Priory Hospital. This is because the Commission has become aware of increasing numbers of patients being transferred to the eating disorder unit from NHS England and occasionally elsewhere in the United Kingdom.

Who we met with

We met with and reviewed the care and treatment of seven patients. No carers, relatives or friends were available to meet with us.

We spoke with the hospital director, clinical service manager, ward manager, a senior nurse and independent advocacy worker.

Commission visitors

Dr Juliet Brock, Medical Officer

Dr Stephen Anderson, Commission Consultant Psychiatrist

Mrs Margo Fyfe, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

On the day of this unannounced visit, the eating disorder unit (EDU) had 20 patients. The other five beds on the ward were occupied by female patients from the upstairs general adult psychiatry ward.

Of the 20 EDU patients, five women were detained, two of whom were being nursed on enhanced observations. Over half of the patients on the ward were from outwith Scotland. All these patients were from England, with the exception of one individual who had been transferred from another EU country.

Care plans and record keeping

On arrival at the unit we were advised that the computer system was not accessible due to routine maintenance. As the hospital notes are electronic, unfortunately this meant we were unable to examine records of patients' current care and treatment. We were however able to meet with patients, speak with staff and refer to information and correspondence held in paper case files for the patients we met. The online system went back online as we left.

We were advised that weekly care plan audits are now taking place and that standards have improved. We were also told that training of junior medical staff had led to improved admission clerking and that this continued to be monitored by consultants. Staff informed us that risk assessments are now reviewed weekly at every ward round and are updated after any incident, together with the patient's safety plan. In the absence of the computerised case files, we were unable to objectively review these changes.

Patient feedback

Among the patients we met with, most felt supported and were positive about staff and the care they were receiving. A number of patients talked about being involved in their care planning and in setting goals for their treatment. Others felt less involved and, particularly where detained, felt they had less say in decisions about their care.

We received mixed responses from patients to therapeutic groups on offer. Some reported these were very good. Others felt these were less helpful and were less keen to engage. There were also differing responses to the amount of individual therapeutic time offered. Some patients said this was good and that they met with their therapist and keyworker every week, whereas others told us this was not happening. Without seeing daily case file entries, again, unfortunately we could not check this in more detail. Staff told us that sometimes individual patients chose not to engage with the therapeutic programme. We were told by the managers that when this is happening on a recurrent basis, as a standard practice, the multidisciplinary team and a patient's home team (where applicable) will always explore the reasons with the individual patient, offering encouragement and support to attend. Where there are barriers to engagement, the team should consider how best to work with the patient to overcome these difficulties. Barriers to therapeutic work must also be considered when English is not a patient's first language, and alternatives (such as one to one work/use of an interpreter) should be offered where appropriate.

Patients transferred from outside Scotland

We are concerned at the high number of patients being transferred long distances for care in Scotland (from England, Wales, Northern Ireland, or occasionally other EU countries), who are sometimes unable to be visited by family and friends due to finances. Individual patients spoke to us about this. Advocacy also advised that patients had raised this issue as a concern.

Managers advised that patients whose family cannot afford to travel to Glasgow are not routinely offered support with transport costs, either by NHS England or their local authority. For some patients this means having very few or no visitors. The Commission recently raised this issue with the Scottish Government.

The hospital has a video-conferencing facility. Managers advise that patients can use this to maintain contact with their family. When we visited, the video-link had been unavailable for several months, but we have been given assurance that a new video conferencing machine is being installed this year. Skype and other online communication platforms are not currently accessible on the ward. For some patients, telephone calls are the only way of maintaining contact with family. For those receiving prolonged in-patient treatment, we are concerned that this infringes on the right to family life, but the new video equipment should help in this regard. For detained patients in particular, the principle of reciprocity is currently not being upheld in this regard.

We explored this issue with managers on the day. In addition to planned repair of the video equipment, they suggested acquiring a tablet device for the ward with Skype access, which patients might use freely. This would be an important step forward for patients. We were pleased by assurances by managers that this would be urgently prioritised.

Recommendation 1:

Managers should ensure that a working system (such as video conferencing or Skype) is available for any patient wishing to maintain 'virtual' contact with close family whilst in hospital.

Use of mental health and incapacity legislation

We were pleased that administrative issues relating to the MHA are now being closely monitored, tracked and discussed at weekly management meetings.

Consent to treatment certificates and certificated authorising treatment for detained patients (T2 and T3 forms) were present in the ward prescription file. However, the forms were not filed alongside each respective patient prescription. It is good practice to file these documents together for each patient, so that nurses dispensing medication can easily check that each treatment is authorised. This is particularly important for agency staff, who will not be as familiar with the patient group.

Recommendation 2:

The ward manager should ensure that T2 and T3 forms are filed alongside the drug prescription sheet for each patien

Rights and restrictions

Enhanced observations

The patients we met who were being nursed on enhanced observation were unhappy with this level of restriction. One individual felt that reasoning for continuing this restriction had not always been clearly explained at the weekly ward round. From our discussions with staff, it appeared that where such restrictions were in place, an appropriate process of clinical decision making had taken place. However, again we were unable to review and verify the recording of such decision making in the clinical notes.

Recommendation 3:

Enhanced observations should be regularly reviewed (in line with the National Observation Guidelines" on good practice), with reasoning clearly documented at each multidisciplinary team (MDT) and fully explained to the patient.

Right to appeal to the Mental Health Tribunal Scotland

The Commission has visited a number of detained patients on the EDU who have been transferred cross-border from England. These patients do not have the legal right to appeal to the tribunal in Scotland until three months following transfer. In a number of cases, the Commission has made reference to the tribunal under s98 of the MHA, for appeals to be heard within this three month period. It is important that all cross-border patients are offered access to advocacy, legal advice and are made aware of their right to appeal. This has not always been done promptly in the past. We were pleased that a MHA administrator has recently been appointed and trust there will be improved monitoring of these issues and patient rights in the future.

We were pleased to hear that the hospital is now using a booklet on the MHA to provide detained patients with information on their rights. Some patients did tell us they had received a copy of this and had found it useful.

Advocacy

Where patients had concerns, they did not always feel these were listened to by the clinical team. We encouraged the use of advocacy services where individuals felt they needed more support in clinical meetings.

Patients did tell us that they were accessing advocacy support and we were pleased to see that a weekly 'clinic' is now being offered and actively promoted by the new advocacy provider at the Priory.

Some posters around the ward still advertised the previous advocacy service, rather than the new one. We found this confusing, as did some patients. Managers agreed to rectify this and ensure information is available about the weekly advocacy clinic and new provider.

We were also told there had been some confusion about advocacy support for patients from England. Those who were previously detained under the English MHA have existing advocacy support locally in England in accordance with English law. These patients were unsure whether also to see the advocacy worker on the EDU. Patients have the right to maintain contact with their local advocacy service at home if they wish. However, managers should make it clear that all patients should be offered Scottish advocacy support with the ward provider during their admission. This is particularly important for detained patients, whose right to make an appeal under Scottish law must be explained and supported.

We were glad to meet with the new advocacy worker, who told us she is actively seeking to offer support to all patients on the unit, whether detained or informal. She highlighted a number of issues that patients had recently raised. These included lack of activities on offer at weekends and concerns about contact with family. The advocacy worker now attends monthly meetings with managers to ensure there is representation of the patients' perspective. General issues raised by patients are being highlighted (anonymously) in this forum. Advocacy will monitor these outcomes for the patient group.

Recommendation 4:

The ward manager should ensure all patients have been offered advocacy support and that patients who are detained are also offered swift access to legal advice, should they wish to consider an appeal.

Activity and occupation

Patients told us that the amount of activities available on the ward was generally varied and good. However, weekend activities are lacking and this was raised as a significant problem, particularly for those patients who are unable to go out on pass or have time at home. As mentioned above, several patients have also raised this with the advocacy service.

Recommendation 5:

Managers should review the activity programme with the ward team and ensure that activities are available to occupy patients at weekends.

The physical environment

The ward environment was described in detail in the previous report and remains clean and in a good state of repair. We were pleased to note that the lift was repaired some time ago and now remains in working order.

Due to the nature of the Victorian building, the corridors on the unit are narrow and the hub around the nursing station and nearby treatment room is limited in space. At certain times of day it appears very busy and noisy.

At others, there appears to be an absence of staff. Whilst the geography of the building cannot be changed, the team might consider how best to meet the challenge posed by the environment, particularly in the central hub of the ward to ensure there is a staff presence when the ward is quiet and also to maintain a calm and therapeutic environment when the ward is busy.

Any other comments

Staff Training

We were pleased to note that hospital managers are setting up new MHA training for staff. We look forward to seeing the results of this in future visits.

Staffing

We did note on this visit that there is currently quite a high level of agency staff on the ward. This is a result of some nursing staff leaving. Where possible, agency staff who are familiar with the ward are booked for shifts. These staff are not specifically trained in eating disorder care and this can sometimes present challenges to the team, particularly in the care of patients who require a high level of support and have complex care needs.

Some patients told us they were aware of agency nurses being on the ward and overall they were positive and did not feel this affected their care. The staff we spoke with told us the core team worked well together, but at times they did feel stretched due to staffing levels on what is a busy specialist unit. We were pleased to hear that new nurses are due to join the team and that further recruitment is ongoing.

IT maintenance and electronic records

We were surprised that routine maintenance of the IT system had been scheduled on a busy clinical day. This was a particular concern given staffing issues. For agency nurses or healthcare assistants who were new to the ward and patients, important information regarding individual care plans and clinical updates was not available for most of the working day. We understand that routine maintenance has to be carried out, but perhaps managers might consider scheduling this during evenings or weekends in future to minimise clinical disruption and reduce the potential risks.

Summary of recommendations

1. Managers must ensure that a working system (such as videoconferencing or Skype) is available for any patient wishing to maintain ‘virtual’ contact with close family whilst in hospital.
2. The ward manager should ensure that consent to treatment certificates are filed alongside the kardex for each patient.
3. Enhanced observations should be regularly reviewed (in line with MWC recommendations on good practice), with reasoning clearly documented at each MDT and fully explained to the patient.
4. The ward manager should ensure all patients have been offered advocacy support and that patients who are detained are also offered swift access to legal advice, should they wish to consider an appeal.
5. Managers should review the activity programme with the ward team and ensure that activities are available to occupy patients at weekends.

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.

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.

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