Mental Welfare Commission for Scotland

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

Date of visit: 6 February 2017

Where we visited

The Priory Hospital Glasgow is a private, 35 bed psychiatric hospital. The hospital currently has two units: an eating disorder facility for women (usually 25 beds), 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 general ward a few years ago. There were no concerns at that time.

We arranged this visit to review current care for general psychiatry and addictions patients at the Priory.

Who we met with

We reviewed the care and treatment of six patients. No patients, carers, relatives or friends requested to meet with us.

We spoke with the hospital director, the clinical service manager, the ward manager, and nursing staff.

Commission visitors

Juliet Brock, Medical Officer (visit lead)

Jamie Aarons, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of this visit, the general unit had 13 patients, all of whom were informal. Seven patients were receiving treatment for substance misuse, the other six patients were receiving treatment for mental illness.

We were told that the majority of patients referred to this ward are privately funded, with few NHS referrals. The length of patient stay is usually between one and four weeks. It is rare for patients in this unit to be detained for treatment under the Mental Health Act.

The ward is mixed, with both male and female patients. Consultant care is provided between seven consultant psychiatrists at the Priory. There are seven ward rounds a week. There is a junior doctor contracted by the hospital who carries out physical health reviews, blood tests, day-to-day reviews and prescribing.

Care plans and record keeping

When viewing the online clinical notes, we found patient care plans to be person-centred and regularly reviewed, with evidence of patient involvement and positive goal setting.

We also saw good documentation of patient involvement in therapeutic activities and one-to-one support sessions. Medical reviews and MDT meetings were also well documented.

At the point of admission to the ward, patients complete and sign a range of documents. These include symptom inventories, forms consenting to treatment and agreeing to a code of behaviour during admission, in accordance with ward policy.

Therapeutic programme

On the ward there is a full therapeutic programme for patients. This is facilitated by a range of therapists in the hospital.

On admission patients join either a four week addictions therapy programme or a four week general therapy programme. We wondered if there were limitations for patients in hospital over four weeks. We heard that on completing a four week therapeutic programme, the therapy team will re-assess an individual patient's needs. Some patients are then recommended to begin the alternative 4 week programme, whilst others may have individual therapy tailored to their needs. We were advised that all therapeutic programmes have a recovery focus.

Prescribing

We reviewed prescribing on the ward at the time of our visit. We found a number of cases where antipsychotic use was recorded for the treatment of insomnia, which is not a licenced use. We were unable to verify whether this had been explained to patients and they had consented to off-licence use. We raised this with the clinical team and managers on the day who advised this would be checked with the prescribing doctors.

Risk Management

A new online risk management tool had recently been set up for use in the service. The online tool includes an initial risk screening form. This is completed on admission, then reviewed and updated by nursing and medical professionals in the team (with a revised form generated approximately every week).

We noted a number of issues with this new system:

- There was little space in the initial risk assessment form to document details of a patient's previous risk history. This was a concern, as we found individual cases in which important risk information was missing from the online screens (both on the initial risk assessment and subsequent screens). In one case we reviewed, crucial risk information was only found on careful reading of the chronological nursing and medical notes and was absent from the designated risk forms.

- We noted multiple examples of errors when risk forms were renewed and updated online. In individual cases, risk factors were being omitted when new screens were generated, and in several cases, lists of new risk factors were spontaneously – and erroneously - attributed to patients. This not only created confusion but potentially had serious consequences for either under or over-estimating the risk profile for individual patients. We brought this to the immediate attention of senior managers who swiftly looked into how errors had been made and how these would be rectified.

Recommendation 1:

Managers must ensure that online risk assessments are being used to accurately record and monitor risk information for all patients. Where staff training in the new online system is required, this must be provided timeously.

Patient feedback

No patients wished to meet with us on this visit. We were, however, able to review patient feedback given in individual case files and found no concerns. Patients complete satisfaction questionnaires following admission and at the point of discharge. Outcomes are reviewed at Quality Improvement Meetings run regularly by senior staff and hospital managers. There are also fortnightly patient forum meetings on the ward, facilitated by a former patient and service user who volunteers. Feedback from these meetings is taken forward via the clinical governance group.

Use of mental health and incapacity legislation

As stated above, the majority of patients receiving care on the ward do so on an informal basis. No patients were receiving care under the Mental Health or Adults with Incapacity Act at the time of our visit.

Rights and restrictions

Given that patients on the ward are rarely treated under compulsory measures, it is important that individuals receiving care are aware of their rights and are not subject to unnecessary or unlawful restrictions.

We noted that in the 'Conditions of Admission', a form which patients sign on arrival, patients are asked to consent to measures such as drug screening, personal searches and their personal mail being checked by staff. We were told that these measures are in accordance with ward policy for maintaining patient safety.

We considered that at the point of admission to hospital, which may be stressful, patients may not have time to fully consider their consent to these measures, or the levels of restriction which might be involved. It was our opinion that more information should be provided to allow patients to give their full and informed consent. The ward does not have an accessible information leaflet for patients about their stay. We understand this is in progress. We would recommend that this leaflet is made available as soon as possible, and that it includes details about ward protocols and any restrictions that form part of the conditions of admission. It would also be helpful to have an information leaflet available for family and carers.

On speaking with staff during our visit, it was not clear that they felt confident in their knowledge of patient rights, restrictions and issues of consent. This is an area that may benefit from further training for the staff team.

Recommendation 2:

Managers should make a patient information leaflet available on the ward which explains patient rights and any restrictions which are in place on the ward.

Recommendation 3:

Managers should consider training needs of staff in relation to patient rights, restrictions and issues of consent.

Advocacy

The hospital have recently made new arrangements for weekly advocacy support on the wards and we were pleased to hear that this was working well and that patients were using and valuing this support.

The physical environment

The ward environment was clean, bright and welcoming. Patients have their own ensuite rooms and there are multiple areas for relaxation and recreation on the ward.

We asked about environmental audit and viewed the environment screening file which contained information from the annual audit of all rooms on the ward. We were advised the last audit had been carried out in August 2016. The forms, however, were not dated or signed to indicate who had carried out the audit. The audits for individual rooms highlighted that towel rails and toilet roll holders required to be replaced with anti-ligature alternatives but we have since been informed that these have all been

replaced. There was no summary sheet or action plan accompanying the file and we were advised that the recommended repairs were still outstanding. This was highlighted on the day with senior ward staff and hospital managers as an issue requiring urgent action. We were assured that the required alterations would be made following the visit and we will follow this up with the service.

Recommendation 4:

Hospital managers should ensure that systems are in place to monitor annual environmental audits and check that recommended alterations are undertaken in a timely fashion, especially when these highlight patient safety issues.

Summary of recommendations

1. Managers must ensure that online risk assessments are being used to accurately record and monitor risk information for all patients. Where staff training in the new online system is required, this must be provided timeously.

2. Managers should make a patient information leaflet available on the ward which explains patient rights and any restrictions which are in place on the ward.

3. Managers should consider training needs of staff in relation to patient rights, restrictions and issues of consent.

4. Hospital managers should ensure that systems are in place to monitor annual environmental audits and check that recommended alterations are undertaken in a timely fashion, especially when these highlight patient safety issues.

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.

Contact details:

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

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk