Mental Welfare Commission for Scotland

Report on an announced visit to: Intensive Psychiatric Care Unit (IPCU), Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 OXH

Date of visit: 5 December 2017

Where we visited

The Intensive Psychiatric Unit (IPCU) is a 12-bedded purpose built facility in Gartnavel Royal Hospital. On the day of our visit there were 12 patients within the unit, all of whom were detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or the mental health provision of the Criminal Procedures (Scotland) Act 1995 (CPSA). We last visited this service on 6 February 2017. The visit was unannounced and there were no recommendations made.

Who we met with

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

We spoke with the senior charge nurse (SCN) and other members of the clinical team.

In addition, we spoke on the telephone with two families.

Commission visitors

Mary Leroy, Nursing Officer

Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The atmosphere in the ward was calm. Patients seemed comfortable in the company of staff and happy to approach them. We saw staff being proactive in engaging with patients. All interactions we saw were warm, friendly and respectful. We saw patients going off the ward in the company of staff during our visit. All the individual patients, and the families we spoke to, spoke positively about staff within the ward. Staff were knowledgeable about patients during discussions.

Care plans were person centred and detailed in terms of physical and mental health. There was evidence that the patient's strengths and abilities were reflected within the care plans, and these were evaluated and reviewed.

We noted that risk management plans were often very detailed and personalised, with information about the interventions needed.

There is a daily safety brief and this communication system helps prepare for the day, allocate resources, and ensure that all relevant information is captured and shared with in the team.

We discussed psychology input into the service. The SCN commented that patients who have been in either rehabilitation or forensic services have access to psychology. However, for the remaining patients it is more difficult to access psychology input. We discussed the value of access to a psychologist where a multi professional approach

could guide assessment, care planning and intervention for patients who may present with more complex care needs.

Recommendation 1:

Managers should review psychology input into the ward to ensure that all patients have equitable access to psychological services if required.

We were advised that pharmacy input is regularly available, and the pharmacist reviews prescription sheets on a regular basis.

There was good attention to physical health care needs, and full physical examination on admission to the ward. Routine physical health monitoring bloods, vital signs, weight and referrals to specialist services are available if required.

The multidisciplinary team meeting (MDT) is held weekly and is attended by the consultant psychiatrist and nursing staff. Other staff attend on an individual basis. In the chronological notes, there was evidence of input from the MDT that included medical and nursing staff, occupational therapist and social worker. This MDT documentation is completed by both medical and nursing staff to a high standard.

Engagement with carers and relative

On the day of our visit we were unable to meet with family/carers, but we were asked to telephone some families who wanted to speak with us. The families we spoke with made very positive comments about medical and nursing staff delivering a high standard of care, being supportive, and having good relationships with them and their relatives. There is a chronological sheet that records carer contact. There is evidence of patients being actively encouraged to think about family contact and whether they want information shared. Those conversations are also recorded in the patients' notes. The staff team have embedded into practice, many processes that augment good communication with carers, family and friends.

Use of mental health and incapacity legislation

All patients on the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995. All documentation relating to their detention was filed in the care plan where relevant.

We reviewed the documentation for one specified person in detail and found specified person forms and reasoned opinion information on file.

Paperwork relating to treatment under part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 was in good order. The relevant consent to treatment forms (T2s and T3s) authorising treatment were available.

Rights and restrictions

Due to the needs of the patient group, the doors of the ward are locked. The ward has access to a safe enclosed garden.

The SCN informed us of a recent local service development 'The Live Standard Checklist'. This document focuses on key information discussed with patients, legal status and advance statement if they have one. It includes explanation to the patient on their treatment, its benefits and side effects. Also, information leaflets on admission for both patient and main carer to receive this information on first contact. This checklist ensures that the patient has there human rights respected at key points during treatment.

Attached below is the Commission's recently published 'Rights in Mind' pathway which is intended as a reference guide and improvement resource for services.

http://www.mwcscot.org.uk/rights-in-mind/

We saw some evidence in the care plans of patients who had advance statements, and also that patients have access to advocacy and legal representatives when required.

Activity and occupation

The recovery model is being used to underpin activities in the ward. Patients we met were engaged in activities, including group activities on the ward and one-to-one escorted outings. Many of the patients had a good activity programme, which was arranged in consultations with the individuals on a weekly basis. This is giving access to a range of recreational and therapeutic activities to meet their needs. This varied programme of activities is delivered by the occupational therapist (OT), patient activity nurse (PAC), an artist, musicians and volunteers.

The SCN also discussed that the nursing staff on the ward take an active role in providing activities. Patients are able to choose from a range of activities; relaxation, gym sessions, movie nights, arts and crafts.

The patients that we met spoke positively about the activities they engaged in, and said that they were encouraged to access a variety of activities. Information on participation in activities was documented within the 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, a well-equipped activity room and a small gym.

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

Any other comments

The SCN told us about extra funding he had accessed. The funding had been used to improve services for patients; a music project, buying music equipment, tai chi classes. We were also informed that the service had accessed further funding for this year. There are plans to arrange a gardening group for the patients and to continue to develop the enclosed garden space.

Summary of recommendations

1. Managers should review psychology input into the ward to ensure that all patients have access to psychological services if required.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date of this report.

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

Mike Diamond
Executive Director (social work)

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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