

Mental Welfare Commission for Scotland

Report on unannounced visit to: Portree Ward (IPCU),
Stobhill Hospital, 133 Balornock Road, Glasgow G21 3UZ

Date of visit: 8 March 2018

Where we visited

The intensive psychiatric care unit (IPCU), has 12 beds and is situated within McKinnon House at Stobhill Hospital. An IPCU provides intensive treatment and interventions to patients who present 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.

We last visited the service on the 4 June 2015, and we made recommendations relating to specified person documentation and the physical environment.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at care planning and activities.

Who we met with

We met with and/or reviewed the care and treatment of eight patients. The visit was unannounced and we were unable to meet with any family or carers.

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

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 the interactions we saw were warm, friendly and respectful. The individual patients we met spoke positively about the staff team. Staff were knowledgeable about patients during their discussions. It was apparent that the team provided highly person-centred care.

We noted that care planning for all the patients were person centred, contained information about the patient's strengths and challenges and were outcome focussed. In some care plans there was clear evidence of patient involvement; patient discussion and with the signing of the respective document. The care plans were reviewed regularly.

Risk management plans were detailed and personalised with information on the interventions required. The SCN updated us on the Scottish Patient Safety Programme, they informed us of recent developments within the ward which focussed

on risk assessment and activities. We were pleased to see this comprehensive approach reflected in the patients risk assessments and safety plans. We were informed that the recent audit of both enhanced observations and physical interventions highlighted a reduction in the need for those specific interventions.

We discussed psychology input into the ward, we were informed that a full-time psychologist had recently been employed to cover the wards in McKinnon House.

The documentation of the weekly multidisciplinary team (MDT) meeting is detailed. We also noted in the patients' files thorough medical reviews and the minute of the meeting provides a good record of progress being made and individual goals being set.

Our visit was unannounced and we were unable to meet with any family or carers on the day. In the patients' files there was a document that recorded contact with carers and families. The staff team spoke of an overall commitment to involve carers in contact with the ward in an open way.

Use of mental health and incapacity legislation

The copies of the certificates authorising detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the MHA), were in the patients' notes.

We examined drug prescription sheets and treatment certificates (T2/3) which were in place for all patients who required them. They were filed with the patient's medication chart, enabling easy checking and reference to be made.

Adults with Incapacity (Scotland) 2000 Act (AWI) s47 consent to treatment authorisations were in order, along with accompanying care plans. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act.

Rights and restrictions

Stobhill IPCU is a locked ward for reasons of patient safety. However, many of the patients had agreed care plans, allowing for short spells of suspension of their detention to allow periods of escorted or unescorted time out of the ward to aid in their recovery.

We became aware during the visit that two of the 12 patients had been in the IPCU ward for periods of time in excess of 18 months which was a situation of frustration to them, and for the staff caring for them, as it is difficult to progress their care. There appeared to be a clinical view from patient records that these patients were not appropriately placed in the IPCU and required a more specialised resources. We will write under separate cover to the responsible medical officer for further information about the length of admission in these cases.

Activity and occupation

Patients we met with were engaged in activities. This included therapeutic group work on the ward and one-to-one escorted outings. People were clearly benefiting from input from occupational therapy (OT) and physiotherapy. Many of the patients we met with on the day commented on enjoyment of access to a small gym within the ward.

We found in chronological notes information of participation in activities and also clear documentation when an activity was offered and if the patient had declined to participate.

We heard examples of staff being creative and flexible in supporting patients to maintain routines and also links with the community. We discussed the 'Restart Programme', this project focusses and offers recovery based support for people living with severe and enduring mental health conditions. The project is an NHS and mental health project working with the community based mental health teams and specialist services in Greater Glasgow and Clyde. The service offers a variety of community based activities ranging from health and wellbeing, horticulture, computing short courses, art and peer support.

We were also told about future plans to employ a patient activity coordinator nurse into the service to assist with the development of a programme of activities for patients at the evenings and weekends.

The physical environment

The ward appeared spacious, bright, well decorated and maintained. The unit consists of 12 single en-suite rooms. There were three separate seating areas, dining room, activity room, small gym, and access to the OT department, which is in the corridor area outside the ward.

Within the ward there is a small room that is used as a 'de-escalation room'. This room is used by some patients when they are distressed, and may require a low stimuli room. During this time of distress, they may need to be nursed separately from others. Other patients may choose to use the room when seeking a quiet area within the ward. We discussed with the staff when a patient is distressed and requires to be nursed in this environment, the clinical team should ensure that there is a thorough risk assessment in place, with a supporting care plan, and that the time and reason for this intervention is documented in the patient's notes. This practice should also be assessed and reviewed on a regular basis within the clinical team.

Recommendation 1:

Managers should review the process and documentation when a patient is nursed separately in the de-escalation room.

On the day of our visit, we saw that outside the dining room area there was a large container that was blocking the view from the dining room and restricting light into the patient dining area. We asked that this was moved as a matter of urgency.

Any other comments

The SCN informed us that they had recently accessed some funding and that they planned to change the de-escalation room into a more therapeutic room that could be used for relaxation.

Summary of recommendations

1. Managers should review the process and documentation when a patient is nursed separately in the de-escalation room.

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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