



Mental Welfare Commission for Scotland

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

Date of visit: 21 May 2019

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 this service on 8 March 2018 and made the following recommendation: managers should review the process and documentation when a patient is nursed separately in the de-escalation room.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendation, and also look at the physical environment including the de-escalation room. This is because we were told on our last visit funding had been made available to change the de-escalation room into a more therapeutic room.

Who we met with

We met with and reviewed the care and treatment of seven patients. On this visit we did not meet with any carers or relatives. We advised the nurse in charge to inform carers and relatives of our visit, and we would welcome contact from carers and relatives should they wish to speak to us following our recent visit to Portree Ward.

We spoke with the senior and deputy charge nurse and other members of the clinical team.

Commission visitors

Anne Buchanan, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The atmosphere in the ward was calm and quiet although it is recognised that this is not always the case and depends on the patient population at any given time. We saw staff being proactive in engaging with patients. Interactions were warm, friendly and respectful. Patients we met with spoke favourably about their care on the ward and nursing staff were knowledgeable about their patients.

We found the majority of care plans had good detail around interventions and evidence of changes to care plans as patients progressed. Risk assessments were detailed and we saw individual safety plans included in patient's records.

There was evidence of 'open dialogue' (sometimes referred to as 'patient conversations') recorded in patient files. Patients we spoke to talked about their individualised 'work book'. This is an opportunity for the patient to think about their illness and what helps them to recover.

Patient care is reviewed at a weekly multidisciplinary team (MDT) meeting. There was evidence of input from medical, nursing, allied health professionals and social workers. Actions and outcomes were clearly recorded in patients MDT forms, and documentation was detailed and of a high standard.

We saw evidence of input from psychology. Psychological formulations are undertaken with outcomes shared with the MDT to assist with understanding patients' presentation and behaviours. Physical health screening was evident, assessments were ongoing, and care plans related to physical health needs were detailed. There are currently two systems for recording documentation. EMIS records chronological and MDT documentation electronically, with all other notes held on paper file. While this is not ideal, we were told EMIS will in the future be able to accommodate all information relating to patients' care and treatment. We welcomed this recent update and hope to see fully integrated records soon.

Engagement with carers and relatives

We saw evidence of carer and relatives' participation recorded in MDT documentation. Nursing staff spoke of their commitment to involve carers and relatives with a 'carer's liaison nurse' having been introduced to provide a point of contact for the ward. On the day of the visit we were unable to meet with carers or relatives. We asked for our contact details to be provided to carers should they wish to speak to us after our visit.

Use of mental health and incapacity legislation

On the day of our visit all 12 patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act) or the Criminal Procedure (Scotland) 1995 Act. Mental Health Act paperwork within the records was well maintained and was easy to access within files. For those patients subject to compulsory treatment, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, with relevant forms authorising medication being prescribed. We were told the ward pharmacist and the clinical team undertake a weekly audit to ensure all forms are in place relating to treatment certificates.

Specified persons

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are subject to detention in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act,

and where restrictions are introduced, it is important that the principle of least restriction is applied.

The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed. We were told that patients who are subject to these procedures are reviewed weekly at the MDT to determine whether the restrictions in place are still required. We found evidence of the reasoned opinion in the care plans and that patients had been informed about their right of review.

Our specified persons good practice guidance is available on the Commission website at:

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

Rights and restrictions

This IPCU is a locked ward and has a 'locked door policy' which is proportionate with the level of risk being managed within an intensive care setting. On the day of our visit there were three patients who required additional support with enhanced observation from nursing staff. We were told patients who are subject to enhanced observations are reviewed daily. The medical and nursing team discuss the patient's care and treatment to determine whether the patient's observation level can be safely reduced. Patients are encouraged to participate with their safety plan and this is recorded in their file.

On the day of our visit we saw patients who were subject to enhanced observations being cared for within their bedrooms. We are aware Greater Glasgow and Clyde Integrated Joint Board does not have a standardised operating policy relating to seclusion of patients. We could not see information in patients' files which identified the rationale for nursing a patient within their bedroom away from other patients.

We are currently reviewing our Use of Seclusion good practice guidance and this will be published later this year. Current guidance can be found on the Commission website at:

https://www.mwcscot.org.uk/media/191573/final_use_of_seclusion.pdf

We were told patients are provided with information about how to access independent advocacy and provided with contact telephone numbers for legal representation.

The Commission has developed [*Rights in Mind*](#). This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

This can be found at <https://www.mwcscot.org.uk/rights-in-mind/>

Recommendation 1:

Managers should ensure that, for patients who are nursed in their room away from others, there is a clear documented rationale and care plan for this.

Activity and occupation

There was evidence of a structured activity plan for each patient whose notes we reviewed. Where a patient cannot participate in a group activity we saw individual therapeutic activities to meet their particular areas of interest or need. Most patients we met were positive about the ward-based activities including access to the ward gym, activity room and input from the ward's newly appointed therapeutic activity nurse (TAN). Additional activities are delivered by the patient activities co-ordinator. They deliver a rolling two week programme of activities which is sufficiently flexible to meet individual patients' preferences. Occupational therapy is provided for two sessions a week. Input from a physiotherapist provides physical health assessments in order for patients to safely use the gym. Patients told us they particularly enjoyed one-to-one therapeutic activities and escorted time away from the unit.

The unit benefits from having its own enclosed garden that is landscaped with plants and shrubs. We were told there is a gardening group which encourages patients to spend time outdoors while maintaining the garden's plants and shrubs. We were told funding has been made available to purchase outdoor gym equipment for the garden. We look forward to seeing this new initiative to promote physical health improvement for patients.

The physical environment

The ward is a spacious and bright and we were told it is due to be re-decorated soon as part of the mental health wards maintenance programme. The unit consists of 12 single en suite bedrooms. There were three seating areas and a dining room, an activity room, a small gym and access to the occupational therapy department. We were happy to see the re-design of the ward's family room. We were told this room has been softened to benefit younger visitors to the unit. The family room was colourful, bright and had a selection of toys, and has been welcomed by carers and relatives.

On the day of the visit we wanted to follow up on our recommendation from our last visit. The recommendation related to documentation when a patient is nursed separately in the de-escalation room. We saw evidence of documentation including 'safe and supportive enhanced observation review' records. The de-escalation room is a room which has been designed to provide a low sensory environment for patients whom require a period of time away from the ward. We were told the de-escalation room had been updated and included new furniture and lighting. However, the room would not be considered a therapeutic space. The room was poorly decorated with rubber matting on the floor which had not been laid well with the potential for causing

injury to patients and staff. The furniture did not look inviting nor comfortable. The walls within the room were bland with no warmth added to the decor. We discussed our concerns with the clinical team on the day of the visit.

Recommendation 2:

Managers should ensure that the de-escalation room is fit for purpose. An assessment of the flooring should be undertaken as soon as practicable.

Summary of recommendations

1. Managers should ensure that, for patients who are nursed in their room away from others, there is a clear documented rationale and care plan for this.
2. Managers should ensure that the de-escalation room is fit for purpose. An assessment of the flooring should be undertaken as soon as practicable.

Good practice

Activities undertaken by both the newly appointed therapeutic activities nurse and the patient activity co-ordinator were highly praised by patients and the clinical team. Activities were organised to meet the needs of individual patients and provided consistently throughout the day.

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.

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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