Mental Welfare Commission for Scotland

Report on announced visit to: Barra and Coll Wards, The Priory Hospital, 38-40 Mansionhouse Road, Glasgow, G41 3DW

Date of visit: 8 July 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face to face visits, however this local visit was able to be carried out face-to-face.

The Priory Hospital, Glasgow is an independent 32-bedded psychiatric hospital. The hospital currently has a 23-bedded NHS funded eating disorder facility for women (Coll and Barra Wards with fourteen and nine beds respectively) and a nine-bedded mental health unit (Tiree Ward) which provides inpatient care for patients with a range of medical disorders including depression, psychotic illness and substance misuse.

We last visited the eating disorder facility on 26 October 2016 and following this visit we made five recommendations relating to patients being supported to maintain contact with their families, consent to treatment certificates, enhanced observations, advocacy support and the availability of structured activities at the weekend.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and the mental health of patients. We also wanted to give patients an opportunity to raise any issues with us and to ensure the care, treatment and facilities are meeting patients' needs.

Who we met with

We met with and reviewed the care and treatment of 11 patients and spoke with relatives. We spoke with the hospital director, the director of clinical services, the clinical director, the therapy service manager, the addictions manager, an administrator, a consultant psychiatrist, a Senior Charge Nurse, a Charge Nurse and other members of nursing staff on the day of the visit.

Commission visitors

Lesley Paterson, Nursing Officer

Douglas Seath, Nursing officer

Anne Buchanan, Nursing Officer

What people told us and what we found

At the time of our visit the eating disorder unit (EDU) had 19 female patients (10 patients and four empty beds in Coll, Barra was at full capacity with nine patients).

Of the 19 patients, 6 patients were detained and three were being nursed on an enhanced level of observation. Of the 19 patients, all but three were from NHS England. This is quite typical with the majority of the patients in the EDU most frequently having been transferred from hospitals in England, usually because their level of acuity is too severe for their local services to manage or the waiting lists for admission to their local hospital are too long or there simply are not enough facilities south of the border to meet the demand.

We were told by senior managers that a lot of thought and time goes into pre-admission screening and much consideration is given to their needs, their risk factors and the other patients on the ward. We also understand that the patient profile is becoming much more complex, with patients being more physically vulnerable. In addition we heard that historically the average body mass index (BMI) on admission was 17.5 but now due to rising acuity, the average BMI on admission is 11.

Care, treatment, support and participation

The patients and relatives we spoke to were generally very positive about the care and treatment provided and spoke highly of the clinical team. They report that staff are friendly, approachable, professional and really seem to care. A number of patients spoke about being involved in their care planning and goal setting, whereas others felt less involved and felt they had less of a say in decisions about their care and treatment, especially if detained.

Two patients described the clinical team as only being focused on ‘the numbers’, (meaning their weight and BMI values). They felt the care could be more therapeutic and trauma focused than it currently is. We discussed this point with senior managers and there was an acknowledgment that in some cases this is an accurate observation, especially with patients who are very underweight and very physically unwell where the primary focus is on increasing their BMI to a safer level.

The EDU has input from four consultant psychiatrists, a resident hospital doctor, (who carries out physical health reviews, blood tests, day-to-day reviews and prescribing), psychology, occupational therapy (OT), dietetics and pharmacy. Each consultant holds a weekly multi-disciplinary team (MDT) meeting and each patient is discussed and reviewed a minimum of once per week but more frequently as is required. In addition, case conference review meetings are held every 4–6 weeks for each patient between the Priory and the home Health Board clinical team. There is a dedicated Care Coordinator who records the MDT and case conference review meeting discussions and regularly liaises with the home Health Board team throughout the patient’s admission.

We reviewed the MDT and case conference review paperwork. Both were well structured, decisions and actions were recorded clearly and there was documented evidence of patient involvement. There was a range of MDT professionals involved in these processes and it was clear to see who attended each meeting.

Risk assessments, risk management plans and patient safety plans were robust and regularly reviewed as part of the MDT meeting and after any incident. There was a clear link between risk, care and treatment. Care plans were person centred, detailed, responsive to needs and reviewed regularly. They were well structured and evidenced collaboration between the patient and the clinical team. As we would expect, there was a big focus on physical health care needs and interventions evidenced throughout the care plans and within the patient's records.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We were told that advocacy input has much improved since our last visit and is available on request. Patients are encouraged to use this service and the patients we spoke with told us they find it valuable, responsive and supportive.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting.

Given that many of the patients in the EDU are being looked after hundreds of miles away from home, we had made a recommendation on our previous visit that videoconferencing facilities must be made available for patients to keep in touch with their families, and we were pleased to see that this in now an established and regularly used feature.

The Priory staff have continued to encourage family contact between patients and their families as far as possible, and patients have been able to maintain telephone or video call contact where appropriate, with a move towards face-to-face when restrictions allowed. Prior to the Covid-19 pandemic there was a carers' support group in place. We heard from both patients and relatives that the latter can sometimes feel 'disconnected' from the care and treatment their loved one is receiving. While we saw some evidence of carer involvement within the patient records, managers acknowledged that liaison between the clinical team and carers could be better. To this end, there is work ongoing to explore this area further and formalise the carers' support structure to ensure they are informed, included, and involved in their loved ones' care and treatment as appropriate. We look forward to seeing how this has progressed at future visits.

Use of mental health and incapacity legislation

Where individuals were subject to detention under the Mental Health Act (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') all relevant current detention paperwork was present in the files.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Unfortunately, not all the correct paperwork was in place and not all paperwork which was in place was accurate.

Section 243 legislation allows medical treatment to be given to a detained patient, without consent if deemed to be required urgently to either save the patient's life, prevent serious deterioration in the patient's condition or alleviate serious suffering on the part of the patient. If it is felt that the treatment may be further required, a Designated Medical Practitioner (DMP) visit should be arranged as soon as possible. If the Responsible Medical Officer (RMO) is continuing treatment until the DMP opinion is given then the urgent grounds specified in s243 must continue to be met. If there is a delay in requesting a DMP opinion, then the treatment given up until that point could be subject to legal challenge. We discussed these specific issues with managers on the day in relation to one case.

Recommendation 1:

Managers should review all current T2 and T3 certificates to ensure they are compatible with current psychotropic medication regimes, that consent forms are present for T2 certificates and that medical staff pursue DMP visits urgently, where required for T3 certificates.

Recommendation 2:

Managers should introduce an audit system ensure that all medication prescribed under the Mental Health Act is authorised appropriately.

Rights and restrictions

One of the wards in the EDU has a locked door (Barra) which is controlled by a keypad. Patients who are very unwell will usually be looked after in this ward. We saw evidence that patients have their rights explained to them in a clear and concise way, and there is a locked door policy which is made available to all patients.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. Although most of the patients in the EDU had chosen not to complete an advance statement, we saw evidence that nursing staff actively encourage patients to consider completing them and revisit this regularly.

Three patients were being nursed on an enhanced level of observation. We saw evidence in the care records that the need for enhanced observations had been recorded and care planned for as appropriate.

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/law-and-rights/rights-mind

Therapeutic activity and occupation

On our last local visit to the EDU, we made a recommendation relating to activity planning, that activities should be made available at the weekends. We were disappointed to hear that, while

the activity programme continues to be reviewed and that there are plans to move to a six-day a-week programme, weekend activities are currently still extremely limited. This view was echoed by the patients we spoke to, with some saying that boredom and lack of stimulation were regular features for them at the weekend, which sometimes had a negative impact on their mental health. Patients told us there is a good variety of therapeutic and recreational activities offered during the week and although we did see evidence of regular activities and therapeutic activities being undertaken on a one to one and small group basis during the week, we do however remain concerned at the ongoing lack of weekend activity provision.

Recommendation 3:

Managers should review the activity programme, ensuring that a range of activities are made available to occupy and engage patients at the weekends as a matter of urgency.

The physical environment

We were told that The Priory spent over half a million pounds on refurbishments last year and the environment was pleasant, bright, fresh and in good decorative order. All bedrooms were en- suite, tastefully decorated and personalised. Both Coll and Barra wards felt calm and noise levels were acceptable. There was adequate sitting and recreation space in the wards and patients have access to a large dining room / café on the ground floor of the building.

Any other comments

We were told by managers that they currently have a high number of staffing vacancies, however this is fairly consistent with many other areas across the country. There is therefore a heavy reliance on agency staff. We were told though that three core agencies are used and every effort is made to block book the same staff members to ensure consistency as far as is possible.

We also heard that efforts to improve the attractiveness of posts, such as increased remuneration, improved terms and conditions are being explored. Encouragingly the staff we did speak to report that they feel respected, valued and receive sufficient training, especially with regards to the increasing acuity and complexity of the patient group. They also receive regular clinical supervision and support from management, which they find invaluable.

Summary of recommendations

1. Managers should review all current T2 and T3 certificates to ensure they are compatible with current psychotropic medication regimes, that consent forms are present for T2 certificates and that medical staff pursue DMP visits urgently, where required for T3 certificates.

2. Managers should introduce an audit system ensure that all medication prescribed under the Mental Health Act is authorised appropriately.

3. Managers should review the activity programme, ensuring that a range of activities are made available to occupy and engage patients at the weekends as a matter of urgency.

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.

SUZANNE MCGUINNESS
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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