Mental Welfare Commission for Scotland

Report on unannounced visit to:
Intensive Psychiatric Care Unit (IPCU), Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 3 March 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The Intensive Psychiatric Care unit (IPCU) is a 12-bedded, mixed-sex, purpose-built facility in Gartnavel Royal Hospital. An IPCU provides care to individuals (aged 18-65 years) requiring intensive treatment and intervention who may present with an increased level of clinical risk and require an enhanced 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.

On the day of our visit, all 12 of the beds were occupied. We last visited this service in March 2024 and we made one recommendation; this related to ensuring that care plan reviews were recorded on a dedicated form that was easily identifiable for staff and was linked with the interventions and support required. The response we received from the service was that managers believed the current form in the paper notes was sufficient. We planned to review this during our visit due to information received of planned system changes from paper care plan reviews to the recording of information on an IT system for the ward.

As this was an unannounced visit, we did not have the same opportunity to make people aware of our visit, so wanted to meet with as many individuals, and speak with their relatives, as possible. We wanted to check progress on any individuals whose length of stay in the IPCU was longer than 6 months and we wanted to hear from staff about their experience of caring for individuals in the IPCU. We also wanted to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

Who we met with

We met with nine individuals and reviewed the care notes of all nine; we also met with one relative. We were able to observe individuals taking part in ward-based activities.

We spoke with the senior charge nurse (SCN), the deputy charge nurse, the consultant psychiatrist, the ward pharmacist, a junior doctor, a trainee general practitioner (GP) and various nursing staff.

Commission visitors

Justin McNicholl, senior manager (projects) / social work officer

Mary Leroy, nursing officer

Kathleen Taylor, engagement and participation manager

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities that were available to them and their views of the environment. We were also keen to review the plans for individuals who had been in the ward for an extended period of time.

Most individuals had had short admissions to the ward, on average of one to two months, although the longest admission to the ward had been for 8 months. Individuals told us that “most of the staff are particularly kind”, “they are working hard in the background to help you get better” and “I know they are short staffed. They are apologetic about it, especially on the night shift”.

There were comments received from individuals that understood the demands that are placed on the nursing staff time. This included, “they are constantly under pressure to complete tasks on the computers in the office, I just wish this was less demanding for them so they could work with us more often, but we do understand they have jobs to do. It’s just frustrating.”

We met with a number of individuals who were unwell and subject to active interventions, which meant that they were being observed in their bedrooms at all times. This varied for some individuals who required one or two members of staff at all times. Some individuals were unable to express any views to us.

Some told us of their frustrations at the restrictions on their liberty stating, “I have to eat in bedroom with my plate on my lap, it’s really uncomfortable” and another individual stated, “I can’t get access to my phone, it’s like prison”. We heard from some that the food is “good” and “fine”.

A number of the individuals expressed concerns about their families, their finances and when they would be discharged from the ward. We heard some positive comments such as “I get to meet with the doctor regularly and know what she has planned” and “it’s helpful attending the MDT to discuss what is working and what is not”.

The relative we met with expressed concerns about lack of access to the MDT, despite being a named person, and the delay in the change to a specific type of medication. The relative was signposted to the complaint’s procedure for the hospital and how to escalate their concerns further.

We heard views from individuals and staff that the ward can be short staffed due to the lack of trained nursing staff. On this visit, five individuals were subject to enhanced observations. There was a gap in staffing related to two nursing staff being absent from the required allocated numbers, and this appeared to have an impact on individuals’ experiences of care on the ward.

We were keen to know whether individuals felt part of their recovery journey, and equal partners in their care and treatment. We observed individuals being invited and welcomed to the multidisciplinary team (MDT) meetings and their views were actively sought. We saw in the MDT meeting records clear evidence of the full views given by the individual that had been recorded in a comprehensive and consistent manner.

We heard from staff that communication in the MDT was excellent, with good information sharing and everyone working together towards reducing lengthy admissions.

All the staff members we spoke with knew the individuals on the ward well and were able to comment on any risks, restrictions and the management plans for each person. The care we observed throughout the day of the visit appeared to be personalised and focused on individual care plan goals. We found evidence that on occasions, when individuals were not keen to participate in activities, there were strategies put in place to motivate and engage them, with noted success.

Compared to our last visit, only two individuals found themselves subject to the Criminal Procedure (Scotland) Act, 1995 (the Criminal Procedure Act). There was a clear understanding with both individuals of the impact of restrictions associated with this.

We heard from managers that staff sickness was a challenge. We heard that there was a consistent intake of newly qualified nursing staff to the ward. It was positive to note that no agency staff had been utilised by the ward, which has helped to provide consistent care and treatment.

Care, treatment, support, and participation

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care and intervention; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We found that individuals in the hospital had care and treatment plans in place to support outcomes and identified goals of nursing care. These were found to be meaningful and were stored in paper files held in the ward.

The majority of the wards we have recently visited in Gartnavel Royal Hospital have transitioned to having nursing care plans on an electronic system. This new arrangement allows for all care plans and reviews to held on one file record. Due to the current paper file system in the IPCU, there was a lack of consistency in reviews. We found that some individuals who had come from other wards had an electronic

care plan whilst others did not. This created confusion around which care plan was the latest version. We were made aware that the ward will be moving to recording care plans electronically in the coming year which will help to avoid any confusion or the occurrence of errors.

A number of the care plans on the standardised template that was being used by staff were incorrectly dated. We asked individuals if they knew about their care plans and the majority of individuals stated that they were not aware of these. We found no consistent evidence that individuals were being asked to sign their care plans. Despite this issue we were able to gather a sense of each individual's mental and physical health that related to the reasons for their admission to the IPCU.

Recommendation 1:
Managers should review their audit processes to improve the recording of care plans to ensure these are consistently dated, person-centred and updated on one system to accurately reflect the patients' current needs and planned interventions.

Recommendation 2:
Managers should ensure that individuals can actively participate in supplying or refusing to consent to care plans.

The Commission has published a good practice guide on care plans[1]. 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.

Participation
Where possible, we heard that individuals were encouraged and supported with all aspects of their care. We observed and found evidence of those that had difficulty engaging in aspects of their care and treatment, or who lacked capacity to make certain decisions, were encouraged and supported to do so. We observed engagement in people's care that ensured there were shared opportunities for a person-centred approach, that individuals were participating, and their will and preferences were acknowledged and prioritised. For example, we observed one individual who liked spending time praying and their individual will and preference was supported without any issues.

When reviewing the care records, we found clear evidence of the individual's journey into the ward had been captured in their notes. We heard from the Glasgow mental health network who highlighted to us that support and access for relatives in the ward was personalised and tailored to their needs. This meant that relatives could visit on a regular basis, at any time other than when there were protected mealtimes and clinical activities planned.

[1] Good practice guide on person-centred care plans: https://www.mwcscot.org.uk/node/1203

We heard that transport links to the hospital were the best available throughout the Glasgow inpatient services. We heard that access to meeting rooms in the ward was never an issue and we were advised that there were no known issues in accessing the doctor or the wider MDT if requested.

Care records

Information on care and treatment was held in three ways; there was a paper file, the electronic record system EMIS and the electronic medication management system, HEPMA, used by NHS Greater Glasgow and Clyde (NHS GGC). The ward had a paper file for each individual that contained their detention paperwork, care plans, admission paperwork, contact details, and information on their GP.

There is a long-term plan in NHS GGC for individuals' records to be held on EMIS, but no exact date has been confirmed for this to occur in the IPCU. We look forward to hearing how this will be implemented for the ward and how staff and individuals adjust to this transition in due course.

We found the majority of records on the electronic and paper systems up to date. The majority of the information was easily accessible and provided a holistic picture of individuals' care needs and their progress. This included occupational therapy, physiotherapy and psychology staff input.

The management of risks in the IPCU is critical due to the level of restrictions placed on the individuals in this type of setting. The CRAFT risk assessments we read were detailed, regularly reviewed, and we saw clear individual risk management plans included in the records. There was evidence of the management strategies used with restricted patients. We observed that the ward had a number of laptops available for nursing staff to use, in order to update records in 'real time'.

Multidisciplinary team (MDT)

The IPCU had a multidisciplinary team that included pharmacy staff, nursing staff, and the ward psychiatrist; the meeting is held at least once a week in the dining room of the ward.

Occupational therapy, physiotherapy, psychology, and music therapy staff provide written reports to the MDT on any progress but do not attend the meeting in person due to the demands of their roles. Referrals can be made by the MDT to all other services as and when required.

Individuals attend the MDT meeting at least once per week, unless too unwell to do so. Individuals are able to obtain an update on their progress, changes to their care or treatment, and where they can ask questions about their progress towards discharge from the ward. We were informed that the psychiatrist would offer to meet individuals on a second occasion at the end of the week if required, to review their

progress and discuss any further changes to their care. This arrangement was reflected in the MDT notes that we reviewed.

The MDT meetings were well documented, with defined actions and outcomes recorded. The notes provided detailed action plans that focused on how to support an individual's progress on from the ward, with clear scenario planning in place. Unlike our last visit, we found clear recording of the title of the professionals in attendance.

We noted that there was a deputy charge nurse post that was vacant for the ward; this role is important as it helps to support individuals and new staff members to the ward. Similar to our last visit, there remains some recruitment challenges for the ward.

We were told that there were no individuals who discharge from the ward was delayed. We were advised that there were no significant issues relating to accessing social workers or mental health officers.

Use of mental health and incapacity legislation

On the day of our visit, all 12 of the individuals in the IPCU were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure Act. Most of the paperwork that was in place was under the Mental Health Act, and the appropriate detention paperwork was readily available.

We heard directly from individuals that they were aware of their rights in relation to the orders to which they were subject. This included easy access to advocacy, with information displayed on a poster at the entrance to the ward. Of the individuals who were well enough to speak with us advised us of having input from a solicitor to represent them at past or forthcoming mental health tribunal hearings, including appeal hearings.

All documentation relating to the Mental Health Act, the Criminal Procedure Act and Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place in the paper files and were up to date.

Part 16 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We examined the hospital electronic prescribing and medicines administration (HEPMA) system that is in place across NHS GGC, that assists nursing staff in the administration of all medication. There was consistency in relation to how the

information on the T2 and T3 forms corresponded to the medication prescribed on HEPMA. The forms that we reviewed were completed by the responsible medical officers (RMO) to record consent, which were found to be up to date, or were in the process of being completed by a visiting approved medical practitioner.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Individuals spoke of nominating named persons to aid them whilst subject to the Acts. Upon reviewing individual records, we found clear documentation regarding these nominations and acceptance of these roles by their family, relatives or friends.

We were informed that an individual had been referred to social work services due to an adult support and protection concern. The form which had been completed that refers any individual under the Adult Support and Protection (Scotland) Act, 2007 (ASP Act) is adult protection one form (AP1). We found no evidence of the AP1 on file or stored on EMIS and there was no alert prompting staff about this referral. The Commission would advise that completed AP1s should always be co-located on EMIS so all staff are aware of what steps have been taken to protect vulnerable patients.

Recommendation 3:
Managers should ensure all adult support and protection paperwork is recorded on EMIS and easily accessible to all staff.

Rights and restrictions

The IPCU is a locked ward and has a locked door policy that is proportionate to the level of risk being managed in an intensive care setting.

On the day of our visit, there were five individuals who required additional support from enhanced observation through continuous intervention with the nursing staff. We were told that the individuals who were subject to these measures were reviewed daily.

When we last visited the ward, we found that staff were required to use seclusion when caring for an individual. There was no use of seclusion taking place during this visit although we heard from staff that there had been some recent use of seclusion for an individual who was no longer on the ward. During our tour of the ward, we revisited the extra care area in the IPCU, which is a space designed to nurse individuals away from the noise of the rest of the ward. This was not in use at the time of our visit and staff explained that this was a helpful resource to have when managing individuals who were struggling with their mental health. Another room that was not in use when we visited was the de-escalation room that could be used for those who are experiencing periods of stress and distress.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained 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.

When subject to specified persons measures individuals could be restricted from making telephone calls, restricted from sending correspondence and/or searched. There were no individuals on the day of our visit who were subject to restrictions.

We heard from one individual who was being denied access to their mobile phone despite not being subject to specified person measures. We shared the individual's request to have access to their phone returned to them and this was followed up with managers after our visit. We were concerned that there was a lack of understanding from staff on the authority to restrict individuals telephones. We signposted staff to our good practice guidance[2] which helps staff understand how these measures are appropriately implemented.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Recommendation 4:
Managers should ensure there is training for staff and appropriate implementation of specified persons measures at all times.

Activity and occupation

We heard from individuals and staff in the hospital regarding the wide variety of activities available. This included playing cards, pool, computer games, art, listening and playing music, singing, walking, access to the gym and various other recreational activities. Much of this work was led by the patient activity co-ordinator (PAC) nurse who led on various activities including the promotion of healthy eating.

It was positive to note that similar to our last visit, there remained a wide variety of meaningful activities arranged in partnership with individuals and staff. During our visit there were posters around the wards advertising musical activities including input from the Nordoff and Robbins music therapist, who visits the ward once a week. The individuals we spoke with praised this input and the work undertaken by staff to help them with their recovery.

[2] *Specified persons good practice guide:* https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The physical environment

The layout of the ward remains unchanged since our last visit. This ward is purpose-built and is light, spacious, well decorated, and well maintained. It consists of 12 single en-suite bedrooms, an additional extra care area, a de-escalation room, and a large communal seating area with an additional quiet sitting room.

The bedrooms were maintained to a high standard, with no concerns raised regarding these living spaces. There was an activity room, a gym with a variety of exercise equipment, and meeting rooms that could be used for family visits. Access to the gym was given when an individual completed a screening process to ensure they could be signed off for unsupervised sessions. Once the relevant form was completed, individuals could fully participate in their exercise goals.

There are two enclosed gardens; one that people can access directly from the communal areas of the ward and this was utilised regularly for individuals to get fresh air and if required, to smoke. There has been a change in the law prohibiting smoking on hospital grounds however the ward had not implemented this legislation to prohibit individuals from smoking in the garden of the IPCU. The second garden is quieter and can be used by those individuals who benefit from a degree of privacy and who may struggle in larger groups or outside spaces.

The day of the visit we found the temperature in the extra care area and de-escalation room to be cold. We heard that this was an ongoing issue in these areas of the ward due to heating issues and lack of insulation to the rooms. We were informed that this could have a direct impact upon individuals when they were cared for in these areas. This has resulted in individuals having to repeatedly request additional blankets to stay warm in while sleeping in these rooms. This was discussed with the staff on the day and requires to be addressed for any individuals who require to be cared for in these rooms.

Recommendation 5:
Service and estates managers should ensure that all improvement works are carried out timeously to the extra care area and de-escalation room.

While looking around the ward, we noted that at the nurses' station the names, legal status and various other additional information relating to individuals was recorded on a board for staff. This board was visible through the main window of the nurses' station and could be read by all who were standing outside this room. We believe this requires to be addressed to ensure individual information is kept confidential at all times.

Recommendation 6:
Managers should ensure that the white board in the nurses' station is fixed to ensure the confidentiality of all individuals in the ward.

Any other comments

While reviewing the records on EMIS we were impressed by the level of recording and therapy delivered by psychology staff to the individuals on the ward. The detail of the information that was recorded helped to illustrate to all who read these records what strategies were in place for the individuals. This included the steps taken to explore their presenting symptoms. The psychology recordings were fully embedded on EMIS and demonstrated good practice with information sharing that could help all in the MDT that provide support and promote recovery for individuals.

Summary of recommendations

Recommendation 1:
Managers should review their audit processes to improve the recording of care plans to ensure these are consistently dated, person-centred and updated on one system to accurately reflect the patient's current needs and planned interventions.

Recommendation 2:
Managers should ensure that individuals can actively participate in supplying or refusing to consent to care plans.

Recommendation 3:
Managers should ensure all adult support and protection paperwork is recorded on EMIS and easily accessible to all staff.

Recommendation 4:
Managers should ensure there is training for staff and appropriate implementation of specified persons measures at all times.

Recommendation 5:
Service and estates managers should ensure that all improvement works are carried out timeously to the extra care area and de-escalation room.

Recommendation 6:
Managers should ensure that the white board in the nurses' station is fixed to ensure the confidentiality of all individuals in the ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

Claire Lamza
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 Commission 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 an individual's care, treatment, and support are 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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