Mental Welfare Commission for Scotland

Report on announced visit to: Ward 1 IPCU

Forth Valley Royal Hospital

Date of visit: 12th October 2016

Where we visited

Ward 1 at Forth Valley Royal Hospital is a 12 bed mixed sex intensive psychiatric care unit. On the day of our visit there were 8 individuals on the unit. We last visited this service on 15th December 2015 and made the following recommendations: the use of legal status summary sheets, appropriate use of T2/T3 forms to authorise treatment where required for detained patients, ward audit of these, and the development of more person-centred care plans.

On the day of this visit we wanted to follow up on the previous recommendations, and look at issues around designating someone a specified person.

Who we met with

We met with and or reviewed the care and treatment of six patients. We met with relatives of three patients currently in IPCU and one who had recently moved from IPCU to an acute ward.

We spoke with the senior charge nurse, charge nurse and the acting clinical nurse manager.

Commission visitors

David Barclay, Nursing Officer & Forth Valley area co-ordinator

Mike Warwick, Medical Officer

Margo Fyfe, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

During the visit we observed good nurse-patient interaction and the patients we spoke with were highly complementary of the care given. Staff were available and approachable and despite the locked setting, there was a calm and relaxed atmosphere. The ward was well staffed and according to the SCN/CN there was no difficulties in managing staffing levels despite recently having gone through a particularly busy period. Staff we met were clearly motivated and had good knowledge of patients we discussed with them. We were told that one of the staff nurses had been nominated by a student for mentor of the year.

We particularly liked the multidisciplinary team (MDT) recording and how this information included who attended the meeting and updated the patients risk assessment. The care plans reviewed were more patient-centred and the interventions clearer than on previous visits. The individuals we met knew that they could have a copy of their care plan if needed.

However, we did notice on one person's care plan that the electronic system had populated a section with outdated material when the care plan was reviewed and updated. There was no information in the strengths and needs section.

We discussed the compilation of care plans at the end of visit meeting. The acting clinical nurse manager explained that the description/goals sections are populated from the admission assessment or the risk profile. In order to gain new content, it was necessary to review the assessment. This seemed cumbersome. The service recognises these difficulties and has designed a new process which will include completing an integrated care pathway electronically from which care plans can be populated. We hope that this can be implemented and look forward to seeing improved care plans on future visits.

Recommendation 1:

Managers should implement systems for fully completing nursing care plans and audit these to ensure that they are comprehensive and of good quality.

Medication

After our last visit we recommended that "if required" medication prescriptions should include a dosage interval. We consider that this is necessary for safe prescribing.

An electronic prescribing system has been introduced since our last visit. We were pleased to hear from staff that they have found this beneficial. We saw prescriptions for "if required" medications that did not include indications or dosage intervals, although there was cross-reference to ensure that maximum daily dosages of the same drug included oral and intramuscular administration. Medical staff thought that it was not possible to also include indications and dosage intervals in the space available. However, the acting clinical nurse manager said it was established that this can be done.

Recommendation 2:

Managers should ensure that medical staff are aware of how to prescribe "if required" medications with indications and dosage intervals and that this is done.

Use of mental health and incapacity legislation

We checked whether patients detained under the Criminal Procedures (Scotland) Act 1995 or the Mental Health (Care & Treatment) (Scotland) Act 2003 had a 'consent to treatment' (T2) or 'certificate authorising treatment' (T3) form in place to authorise medication where a form was required.

One patient was prescribed IM "if required" psychotropic medication without a T3 form in place to authorise this. We have concerns about intramuscular 'if required' medication being prescribed if it is not covered by a T3 form.

This is because it is likely that the patient would not be consenting to receive the treatment if it was later administered. We discussed this with the senior charge nurse on the day and also wrote to the Responsible Medical Officer (RMO).

Another patient who required a T2 or T3 to authorise medication they were prescribed did not have a form in place. We discussed this with the RMO.

Recommendation 3:

The Responsible Medical Officer must ensure that prescriptions of medications for detained patients are properly authorised, with a T2 or T3 form in place where this is required by the law.

Adults with Incapacity (Scotland) Act 2000 s47

One patient we met had a s47 certificate and treatment plan in place to authorise treatment for physical disorder. An entry for 'fundamental healthcare procedures' was included, but there were other general entries that did not specify or cover other individual conditions the patient was receiving treatment for.

Information about how doctors should correctly complete a s47 certificate/treatment plan is contained in the Code of Practice for Part 5 of the Adults with Incapacity Act:

http://www.gov.scot/Publications/2010/10/20153801/0

Recommendation 4:

Managers should ensure that medical staff are trained in correct completion of Adults with Incapacity (Scotland) Act 2000 s47 certificates and treatment plans. All medication that a patient is receiving under the Adults with Incapacity Act should be properly covered.

Specified persons procedures

We were keen to discuss the issue of room searches and who was required to be made a specified person for this. At the last visit there was uncertainty about this issue and we wished to clarify it with the senior nursing staff. Staff told us that room searches were routinely carried out on a rotating basis, 3 rooms a day. They were clear that if someone didn't consent to this, then they would require to be made a specified person for this.

There seemed to be a lack of understanding that if a patient is detained, whether on civil order or criminal procedures act, that they should be made a specified person in order to obtain random urine or breath specimens to test for drugs or alcohol.

Recommendation 5:

Managers should ensure that all patients who are detained should be made specified persons if they are required to provide urine or breath specimens for drug or alcohol screening.

Rights and restrictions

We met with one person who was not detained. He had recently been admitted as there were no beds available in local open acute wards. The patient was aware that he could have escorted time out of the ward and that he could leave at any time he chose.

There is an enclosed garden area just for the use of the ward patients and staff; this is a pleasant area though it seemed underused. Also, the garden had no night lighting so it couldn't be used during the hours of darkness.

One patient discussed with us restrictions to their time off the ward. We clarified with the Scottish Government after the visit that the RMO has the authority to permit this patient to have escorted time out, and they have now done this.

Activity and occupation

It was acknowledged that there is a lack of activities provision in ward 1. Nurses attempt to run one to one and group activities but the clinical demands of the patient group mean that nurse led activities are often cancelled. Ward 1 has its own small gym with cardio equipment; patients must be accompanied by a nurse trained in the use of the equipment. There has been a change in the Occupational Therapy (OT) input to the ward. There was an OT giving one afternoon a week to do activities such as baking or games, however due to staff sickness/absence this has not been available for the last few months. The OT visits the ward most days to take individual referrals. Patients we spoke with did mention the lack of structured activities and said they felt bored at times. In reviewing files we noticed that activity care plans were not evident either.

Recommendation 6:

Managers should review the activity provision in ward 1 and the development of activity based care plans, to ensure a specific level of activity.

The physical environment

It was noticed by commission staff that there was significant areas of damage to the walls and furniture in a few of the bedrooms. There were broken windows that had been sealed and made safe but they still looked unsightly, and we thought that patients should not be placed in those bedrooms. Staff said that these rooms were not usually used and they have been waiting for some weeks for the windows to be replaced.

Unfortunately, the contractor who runs the hospital will only order the windows when there is a significant number to be replaced as they are custom built.

The ward décor remains stark and clinical; there had been some coloured wall panels installed in the corridor and lounge areas since the commission's last visit but no wall mounted pictures. This was due to safety issues of patients pulling these off the walls. Staff acknowledged these particular environmental issues, but felt that they were restricted in how best to progress these.

Recommendation 7:

Hospital managers to pursue estates contractor to ensure necessary repairs are completed as soon as possible and rooms with broken windows should not be used until windows replaced.

Summary of recommendations

1. Managers should implement systems for fully completing nursing care plans and audit these to ensure that they are comprehensive and of good quality.

2. Managers should ensure that medical staff are aware of how to prescribe "if required" medications with indications and dosage intervals and that this is done.

3. The Responsible Medical Officer must ensure that prescriptions of medications for detained patients are properly authorised, with a T2 or T3 form in place where this is required by the law.

4. Managers should ensure that medical staff are trained in correct completion of Adults with Incapacity (Scotland) Act 2000 s47 certificates and treatment plans. All medication that a patient is receiving under the Adults with Incapacity Act should be properly covered.

5. Managers should ensure that all patients who are detained should be made specified persons if they are required to provide urine or breath specimens for drug or alcohol screening.

6. Managers should review the activity provision in ward 1 and the development of activity based care plans, to ensure a specific level of activity.

7. Hospital managers to pursue estates contractor to ensure necessary repairs are completed as soon as possible and rooms with broken windows should not be used until windows replaced.

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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