mentalwelfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: IPCU (Ward 1), Forth Valley Royal Hospital, Stirling Road, Larbert, FK5 4WR

Date of visit: 8 November 2018

Where we visited

Ward 1 at Forth Valley Royal Hospital is a 12-bedded, mixed-sex intensive psychiatric care unit (IPCU). On the day of our visit there were 10 patients on the ward.

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 7 November 2017 and made recommendations about reviewing the provision of psychology and occupational therapy (OT) services to the IPCU, and making the ward environment less clinical in appearance.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of six patients. We did not have the opportunity to meet with carers/relatives/friends on the day.

We spoke with the clinical nurse manager, the senior charge nurse, the lead nurse for adult mental health, and the ward consultant.

In addition, we saw representatives from the local advocacy service who were meeting with patients on the day.

Commission visitors

Yvonne Bennett, Social Work Officer

Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

All the patients we spoke to during the visit advised that they felt they were receiving good care and treatment within the unit. They described the staff as friendly, approachable, and supportive. Two patients reported that they felt safer within this environment than they had for some time.

We saw care plans which were detailed, person centred and addressed a wide range of needs arising from complex and mixed diagnoses. Within these care plans there was evidence of patient involvement. We heard that the service was planning on purchasing hand-held computers which will further promote patient inclusion in the formulation of care plans in real time.

Risk assessments were thorough, detailed, and regularly reviewed.

We heard that the multidisciplinary team meetings were held twice weekly, but that the composition of these meetings often only involved the consultant psychiatrist and the nursing staff. Psychology services are not involved with patients within IPCU. On our visit to the ward last year we heard that psychology provision to the ward was limited, but this situation has deteriorated further with clarification that there is no capacity for psychology services to IPCU. This is a concern, particularly in light of the complex nature of the presentations this service manages.

We also saw that OT provision to the ward is limited. This was reviewed following a recommendation from last year's visit, and three sessions of OT provision were allocated to the ward. We heard, however, that due to OT staff sickness this provision remained limited and that OT assessments remained outstanding.

We will write to the service separately for further information on these issues.

Use of mental health and incapacity legislation

On the day of this visit, all 10 patients were subject to the Mental Health (Care & Treatment) (Scotland) Act 2003 (MHA). Patient records contained the appropriate legal paperwork and all 'consent to treatment' certificates (T2) and 'certificates authorising treatment' (T3) were current and appropriate.

One patient was subject to a welfare guardianship order and there was a copy of this order on record, detailing powers and contact details for the guardian.

Sections 281 to 286 of the MHA provide a framework within 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 MHA, 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.

Currently all 10 patients are specified persons based on assessment of individual risk and appropriate paperwork in place.

Advocacy is readily available and visit the ward at least weekly.

Rights and restrictions

The ward operates a locked door policy which continues to be appropriate in light of the levels of risk being managed within the ward. Patients have access to an enclosed garden space. There is a no smoking policy across the site, and patients are offered nicotine replacement options as an alternative.

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/

Activity and occupation

On this visit we heard that, within the mental health unit, three activity co-ordinator posts have been created and recently filled. This allows for dedicated capacity to promote and develop activities across the five mental health wards. This development is in its infancy and we look forward to seeing how this progresses.

Within the ward there was an acknowledgement that the acute phase of illness can impact on patients' ability to engage in meaningful activity, and that this can fluctuate dramatically on a day-to-day basis. During the visit, we saw nursing staff engaging in a range of activity with patients on an individual basis, and evidence of this engagement recorded within patient records.

The physical environment

The ward comprises 10 single bedrooms with communal living and dining areas as well as an activity room and small meeting rooms. Soft furnishings have been purchased within the communal areas which reduces the clinical appearance and provides a more homely environment for patients.

Any other comments

There has been a fairly high incidence of sickness amongst the staff group in Ward 1 and a need to use a higher than usual number of bank staff. However, there would appear to be a fairly settled group of bank staff who cover within the ward, and so the consistency and quality of care provided appears unaffected.

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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