mentalwelfare commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Blackford Ward, IPCU, Royal Edinburgh Hospital, Edinburgh EH10 5HF

Date of visit: 24 January 2018

Where we visited

Blackford Ward is the intensive psychiatric care unit (IPCU) for NHS Lothian. It has 10 beds for both male and female patients and has a separate high dependency suite.

The nursing team include a senior charge nurse (SCN), supported by two deputy charge nurses (DCN) and a team of registered nurses and nursing assistants.

There is a consultant psychiatrist, a specialist psychiatric registrar and junior doctor support. There is dedicated time from occupational therapy (OT), input from the clinical nurse specialist for self-harm, and referrals to clinical psychology are made on an individual basis.

This is the first time the Mental Welfare Commission (the Commission) has visited the new ward, which has been open for approximately seven months.

This was an announced visit, the last local visit being on the 26 of April 2016.

Recommendations from the last visit were to increase the level of person-centred content and summative evaluation in care plans, and develop systems for debriefing patients. A service response to the recommendations was received. It indicated that there had been person-centred care plan training developed for nursing staff, ward level audits had been put in place and there had been an updated format for debriefings.

Who we met with

On the day of our visit, we met with three patients, and the relatives of one patient. We reviewed the care plans of all six patients who were in the unit at the time of our visit.

On the day, we met with the clinical nurse manager (CNM) and throughout the day we had an opportunity to talk to members of the nursing team, the consultant psychiatrist and OT staff.

Commission visitors

Claire Lamza, Nursing Officer (visit coordinator)

Alison Thomson, Executive Director (Nursing)

What people told us and what we found?

Care, treatment, support and participation

The patients we met with on the day were able to tell us that they felt safe and well looked after by the staff. Patients in an IPCU are in a more acute and distressed stage of their illness, and in Blackford Ward the people we spoke to explained that the staff

in the unit dealt with any challenging situations quickly and quietly, which was reassuring for patients and their carers.

On the day of our visit, we were able to observe staff engaging with, and supporting patients. The positive relationships between patients and staff was evident and we were told about different aspects of care that the ward staff – nursing, OT and psychiatry - had promoted, that had been helpful in terms of patient care.

While one patient we met with raised concerns about being detained in the IPCU, we could see from the care plan that staff had discussed and gone through the patient's rights. Advocacy was also involved and there was clear evidence in the care plan of activities to provide structure and reduce the impact of detention.

In all patients' care plans we found detailed assessments, written by medical staff at the time of admission, as well as OT assessments. They provided clear information about the patients' clinical presentation, their strengths and areas where care and treatment could be provided that would improve their mental wellbeing.

These documents were available in the patients' paper-based care plans, although further information relating to care and treatment was held electronically. We found information in both systems that provided a defined and person-centred approach to patient care. Blackford has an adapted version of the care plan that is used in the other acute admission wards at the Royal Edinburgh Hospital. For those patients who have been transferred into the ward, they continue to have the admission ward care plan; direct admissions have the Blackford Ward care plan. The IPCU plan covers needs, aims, intervention and evaluation.

While both versions of the patient's care plan have sections that are helpful, we found that the IPCU version included a mechanism for ensuring that there was an evaluation. We found completed evaluation dates, but there was a lack of detail about the progress that the patient had made in relation to the prescribed interventions.

Recommendation 1:

Managers should develop the existing evaluation section to provide more detail relating to the outcomes of the patient's care.

Use of mental health and incapacity legislation

When we visited, all of the patients in Blackford were detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or under the Criminal Procedures (Scotland) Act 1995. No patients were under incapacity legislation, although one patient had a Department for Work and Pensions appointeeship in place, with a copy available in their paper-based records.

Copies of mental health act documentation were in the patients' care plans, and certificates authorising prescribed treatment (T2/3) in place as required.

Rights and Restrictions

We were pleased to find evidence in patients' care plans that indicated that their rights were discussed with them at the point of admission. There were copies of leaflets given to patients that detailed 'your rights under the mental health act'. The section in the care plan that noted whether this had been given to the patient, and an acknowledgment if the patient had, or had not, agreed to go through this with staff was also completed.

On the day of our visit, some of the patients we spoke with made us aware of the support that nursing staff offered as they made their application to the Mental Health Tribunal for Scotland. We found that those patients who opted to, had access to legal advice and had identified a named person.

In addition to this, the patients we spoke with and the notes we reviewed all indicated that patients were aware of their rights, and had access to advocacy. We noted that there was information available in the ward, with contact details for the service.

None of the patients who were in the ward were subject to restrictions as a specified person. We were advised that if this was required it would be kept on the electronic system along with a hard copy in the patient's care plan.

We found the recording and information associated with pass plans/time off ward and level of observation to be detailed and helpful. We were also pleased to see well defined risk assessments that were up to date and person centred.

This visit offered us the opportunity to see the newly designed high dependency suite, which is used when patients require a period of seclusion. While this facility is safe and fit for purpose, we considered grey coloured walls to be less than conducive in creating an environment that would help improve the patient's distress. We were told that there are plans to redecorate the suite in another colour.

We were provided with the current standard operating procedure related to seclusion, and were able to review both the paper and electronic documents for those patients to whom this applied. We found that on the occasions that seclusion had been used, the procedure in the policy was followed diligently. At the defined review points, medical and nursing staff assessed the use of seclusion and its impact on the patient, and the recordings that were made were informative and timely.

Physical Environment

We were pleased to see such a marked improvement in the new IPCU; the environment has improved significantly; the ward feels spacious, light and has a good range of different areas for patients to access. Access and egress to the wards is locked, although we noted that there were members of staff available to assist patients who were able to leave the ward.

All patients have their own en-suite rooms and access to a bathroom, should this be preferred. There is a day area, which also has a dining area, access to a spacious courtyard garden, a therapeutic kitchen, a gym/recreational space and an art room. The environment has used colour and patient artwork has been encouraged to add to visual impact of the unit. The large windows and seats that overlook the garden add to the light and bright feel of the ward.

We discussed future developments to the environment and there are plans to enhance the courtyard garden, the interview room and the artwork in the unit.

Activity and occupation

We were impressed with the detailed OT assessments that identified activities and interests defined to improve the functioning of the patient. We were also pleased to see the variety of activities that were available for patients in the ward. On the day of our visit we found that there were patients engaging in an art group, patients on escorted outings and visits taking place with family members and their children.

There was evidence of the use of weekly activity schedules and this was reported in the patient's electronic progress record. We did note that where a patient was offered an opportunity to participate in activities and chose not to, this should be recorded. This will be helpful when evaluating the patient's progress, as noted in recommendation 1.

The patients we spoke with told us that being able to participate in activities such as cooking sessions, the gym, and escorted walks had a positive impact on their mental health and helped them build skills that would be useful upon discharge.

We were made aware that at present the recreation nurse post is vacant. We were informed that there are alternative models that could be used to ensure that patients can routinely access amenities, and the SCN and CNM are currently discussing options. Activities are on the ward, such as attending the gym, and off the ward outings to the local community. These are likely to be adversely affected if there is a delay in having a nurse designated specifically to supporting activities.

Summary of recommendations

1. Managers should develop the existing evaluation section to provide more detail relating to the outcomes of the patient's care.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date of this report.

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

Alison Thomson
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 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk

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national
preventive
mechanism