Mental Welfare Commission for Scotland

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

Date of visit: 22 January 2019

Where we visited

Blackford Ward is the intensive psychiatric care unit (IPCU) for the city of Edinburgh, East Lothian, and Midlothian. It is a 10-bedded mixed-sex unit with a separate high dependency suite. 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 January 24 2018 and made a recommendation about the evaluation of patient care. For this visit to Blackford, we wanted to meet with patients, follow up on our previous recommendation, and look at general issues that were important for patient care.

Who we met with

We met with and/or reviewed the care and treatment of five patients. We spoke with the senior charge nurse (SCN), members of the nursing team, the consultant psychiatrist for the unit, and the clinical nurse manager (CNM).

Commission visitors

Claire Lamza, Nursing Officer

Tracey Ferguson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Our visit was, on this occasion, unannounced, so patients, relatives, and staff had no prior warning or notification of our arrival. They did not have the opportunity to plan for contact with us, or arrange appointments with us.

Those that we spoke to were positive and complimentary about support they had received from different members of the multi-professional team. The patients gave us their views in relation to the constraints of being in the IPCU**,** but told us that the reasons for the restrictions were explained to them and that staff were available to discuss these reasons.

On the day of our visit, we observed staff skilfully support and care for patients who were distressed at being in the ward. We found that de-escalation of potentially challenging situations was done quietly and efficiently, and patients were given clear information about planned interventions. We found staff to be responsive in meeting the diverse needs of the patient group.

While the majority of patients in Blackford were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), a number of patients in the ward were informal. We discussed this with the SCN, the consultant psychiatrist, and the CNM, and were made aware that patients who do not need to be cared for in this environment are being admitted to the IPCU due to a lack of beds in the adult acute wards. The Commission is aware of the current work being undertaken by managers to ensure bed availability within the hospital.

The Commission knows that there are occasions when an informal patient may be in an IPCU ward. We feel generally that, because the function of an IPCU ward is to provide care and treatment to patients who require intensive support, who will be very acutely unwell, and who may display significantly stressed/distressed behaviour, the admission of informal patients to an IPCU ward may often not be appropriate.

We were reassured that any patient who was an informal patient in the IPCU ward was made fully aware of their status and that they could leave the ward when they asked to.

Recommendation 1:

Managers should keep the admission of all informal patients to IPCU under review to ensure they are consenting to the admission, understand their rights in relation to leaving the ward, and aware of other restrictions.

The care plans that we looked at varied in terms of the level of detail. A few patients had been in the unit for a period of weeks, while the remainder had only been in Blackford for a matter of days. With those patient who had been in longer, there were care plans and detailed reviews using the SCAMPER pro forma for multi-disciplinary reviews. While the standard of the daily progress notes was good, there was inconsistent completion on other forms. Admission details, personal details, and information about the episode of care were incomplete on the relevant forms.

Recommendation 2:

Managers should audit the documentation to ensure that all sections are completed.

While the progress notes and SCAMPER reviews were reasonably person centred, individuals either did not have care plans or they were nominal. One of the patients who had been in the unit for several weeks, and was due to be transferred, had one care plan. We raised this with the SCN, who explained that the care plan documents and accompanying guidance is under review at present. We would anticipate that by the time of our next visit, the updated care plans will be in place.

Use of mental health and incapacity legislation

For those patients who were detained under the Mental Health Act, all of the paperwork pertaining to short-term detention orders and compulsory treatment orders was located on the electronic system. There were no patients under the Criminal Procedures (Scotland) Act 1995, or Adults with Incapacity (Scotland) 2000.

We found forms for consent to treatment under the Act (T2) and forms authorising treatment (T3), with a further copy kept with the medication prescription sheet**.** All medications were appropriately prescribed and administered according to the patient's status.

Sections 281 to 286 of the Mental Health Act 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 Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. There was one patient who had restrictions in terms of their use of telephones. We were pleased to find the completed forms on TrakCare, along with a copy of the letter given to the patient explaining the restrictions and their right of appeal, and an associated care plan detailing the interventions for clinical staff.

Rights and restrictions

Those that we spoke to advised us that they had access to advocacy and legal representation, and during our visit we observed a newly admitted patient having a visit from both the advocacy worker, and their solicitor.

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/

There was information regarding pass plans, time off ward, and level of observation, that was easily located and detailed. However, some of the risk assessments had not been updated to reflect changes in an individual's observation status when this had increased, and a recently admitted patient had no risk assessment in the care file.

Recommendation 3:

Managers should ensure that risk assessments are completed and updated at appropriate times.

In our previous visit, we had commented on the environmental aspects of the high dependency suite. We were disappointed to see that there has been no improvement.

Recommendation 4:

Manager should make the recommended environmental changes to the high dependency suite.

The patients in the IPCU who were informal were scheduled to be moved to the acute admission wards at the earliest possible time. We were made aware that the issue is raised daily by the SCN, and by the consultant psychiatrist, at local bed management meetings. We were also informed that the SCN and the consultant are developing a mechanism whereby patients who are informal, but have a bed in the IPCU, will be made aware of, and give their agreement to, staying in a more restrictive environment than they require.

Activity and occupation

We found evidence of patients being offered, and participating in, a range of activities on and off-ward. The patients told us that staff supported them with escorted passes out to the local community based amenities, and that they could access the clubs and day services provided across the hospital site. The on-ward activities such as the art group, coffee mornings, playing pool, and accessing the gym were also described positively by those that we spoke to.

We noted the centrally located activity planner that identified scheduled options for patients, and found assessments completed by the occupational therapists which defined the patient's activities and interests. Participation and engagement was documented in the progress notes.

We were advised that the activity co-ordinator post will be filled in the near future, and we look forward to reviewing the impact of this role on patient care when we next visit the ward.

The physical environment

The environment continues to be well maintained, bright, spacious, and pleasant. There are various areas where patients can sit and spend time with staff, as we observed on the day of the visit.

All patients have their own en-suite rooms, and access to a bathroom if preferred. There is a day area which has a dining area, access to a spacious courtyard garden, a therapeutic kitchen, a gym/recreational space, and an art room.

Any other comments

When we met with the SCN and the consultant psychiatrist, we discussed the changes in the clinical team since our last visit. The SCN and the psychiatrist are new to the IPCU, and a new charge nurse has recently been appointed. This newly formed team have plans to review the policies and processes for the IPCU, as well as monitor the admissions and the length of stay.

Summary of recommendations

Recommendation 1:

Managers should keep the admission of all informal patients to IPCU under review to ensure they are consenting to the admission, understand their rights in relation to leaving the ward, and other restrictions.

Recommendation 2:

Managers should audit the documentation to ensure that all sections are completed.

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Recommendation 4:

Manager should make the recommended environmental changes to the high dependency suite.

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

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