Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 1, IPCU, St John's Hospital, Livingston, EH54 6PP

Date of visit: 21 February 2019

Where we visited

The intensive psychiatric care unit (IPCU) is a 12-bedded, mixed-sex unit on the lower ground floor of St John's Hospital. It provides care for patients between the ages of 18 and 65 years, all of whom are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedures (Scotland) Act 1995 (the Criminal Procedures Act).

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.

The unit accepts admissions mainly from the West Lothian area, although there are admissions from other parts of NHS Lothian, as well as a service level agreement for access to two beds for patients from NHS Borders.

We last visited on 14 March 2018, and made recommendations to review the input of pharmacy and on specified person paperwork. On the day of this visit we wanted to follow up on the previous recommendations, and also look at developments in the multi-disciplinary team and managing bed pressures across NHS Lothian.

Who we met with

We met with and/or reviewed the care and treatment of five patients. There were no relatives/carers that wished to meet with us on the day of the visit.

We spoke with the senior charge nurse (SCN), the charge nurse (CN), and members of the nursing team. Feedback at the end of the visit was to the SCN and CN, as well as the clinical nurse manager for older people's services (CNM) and the lead nurse for mental health.

Commission visitors

Claire Lamza, Nursing Officer

Dr Mike Warwick, Medical 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, or arrange appointments with us.

The patients that we spoke to described staff in positive terms. They told us that staff were approachable, that they are visible and available for patients, and were supportive in responding to the patients needs whilst in the ward. On the day of our visit, we were able to see this for ourselves. We saw staff respond in a helpful and caring manner to patients who were visibly distressed as a result of the combination of their mental health symptoms and with being in the IPCU.

Patients told us their views of being in this type of ward. While they found the restrictions of a locked environment difficult, and the behaviours of some patients challenging, those that we spoke to told us that they had raised their concerns with staff, and that these were addressed. Patients told us that they felt that they had progressed while in the ward, and that their illness and symptoms had reduced since admission.

We also spoke to the SCN and CN about developments that have taken place in terms of patient care. We were disappointed to hear that there has been no development in terms of the provision of pharmacy. While we recognise that medical and nursing staff are well placed to manage the medication needs of the patients in the unit, having dedicated time from a pharmacist would be of benefit to the team. Some prescribing practices, while correct, may have been managed differently with the input from this professional discipline.

Recommendation 1:

Managers should review the pharmacy service to the IPCU.

We were made aware of the positive impact that changes in the multidisciplinary team (MDT) have had on the weekly review process since psychology input has been introduced. The use of formulation has promoted more positive risk taking approaches to patient care, and the team explained some of the benefits that they have noted from having input from this discipline.

There has also been an additional session for patients to meet with their consultant psychiatrist on a self-booking basis. The “talk with the doc” clinic runs weekly on a Friday morning, and patients can select a slot in the open appointment system if they wish to discuss any aspects of their care prior to the weekend.

We reviewed the paper-based care plans, and found them to be well organised and tidy. At our last visit, we were advised that the care plan document was to be reviewed. We were told that this work is ongoing. The care plans that we saw defined each patient’s existing problems in a personalised way, and the aims continued to be person centred. The level of detail varied in the interventions section, and the evaluation/outcome section was generic.

We discussed this with the SCN and CN on the day. They told us about the peer audit process, which takes place every six months, and the ongoing work with the nursing team in the unit around the writing of care plans.

Recommendation 2:

Managers should continue to develop a person-centred approach with the intervention and outcome sections of the care plans.

The care plans also provided evidence of how the patient was progressing. We could see this through the recordings in the daily notes, the defined one-to-one sessions with nursing staff, and the multi-disciplinary record, and we were pleased to see the patient's views and their strengths incorporated into this document.

Use of mental health and incapacity legislation

On the day of our visit, the majority of the patients in the unit were being treated under the Mental Health Act. The remaining patients were there for assessment under the Criminal Procedures Act. We found all of the relevant paperwork regarding the detentions on "TrakCare". We asked about any issues with out-of-area admissions or patients being admitted informally, and discussed a recent out-of-area admission where there was a delay in returning the patient to a less restrictive environment. The SCN and CN explained that the MDT are considering reviewing the admission policy for admissions out with the NHS Lothian area.

We noted there was good practice in terms of a regular audit programme that reviews the use of consent to treatment (T2 and T3) forms, evaluating medication that was covered and if copies were located in the drug prescription sheet. We found consent to treatment certificates (T2) or certificates authorising treatment (T3) were in place, and prescribed medication was authorised appropriately. We noted that some medications were prescribed in an irregular way and raised this at the visit, so that nurses could be clear about the administration of medications.

For those patients in the ward who were under specified persons guidance, sections 281 to 286 of the Mental Health Act provides a framework within which restrictions can be put in place. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

We noted that the registered nurses have signed the RES 1 and RES 3 forms for those patients who are specified in some instances, and in others the resident medical officer has signed the forms.

Recommendation 3:

Managers should ensure specified persons procedures are followed in relation to completion of the necessary forms.

There were no patients who were under the Adults with Incapacity (Scotland) Act 2000.

Rights and restrictions

There were no patients on constant or intensive levels of observation on the day of our visit. We discussed the pending guidance from Healthcare Improvement Scotland (https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention) and advised the SCN and CN to consider reviewing this with their colleagues.

We found that risk assessments were detailed, individualised, and were reviewed and updated regularly. There were details where a patient had accessed advocacy or had legal representation and, where relevant, this was recorded in the patient's file. We did not find any evidence of advance statements in the care plans that we looked at. 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

We were pleased to find that the ward offers a range of activities, and found evidence of this in the care plans we reviewed. There is also a useful document that records the patient's engagement in the activities that are on offer, and a brief evaluation of this.

The activity programme was visible on the wall outside the main day area, and we noted that activities are available throughout the day, in the evening, and at weekends, provided by nursing, occupational therapy, and physiotherapy staff. The range of groups included art, mindful drawing, pamper sessions, games, the smoothie group, and escorted outings, as well as structured sessions with different clinical staff. We were told that a future development will be around psychological interventions, supported by the psychologist.

The other new development has been the re-design of one of the larger rooms in the ward, which has now become a gym. Nursing staff and the physiotherapist assess and support patients who wish to access the gym. The physiotherapist had also been able to access funds to support the request from patients for a punch bag. The new free-

standing bag sits in an accessible, but visible, space in the unit, and we were advised that it is well used.

The physical environment

The ward is spacious, with the main patient areas in the middle of the unit. There are a range of rooms offering different functions – a large TV lounge, a pool room with a punch bag that was requested by patients, a multi-purpose room with a kitchen, and the newly added a gym. We were told that redecoration of the ward has just begun.

There are en-suite bedrooms at the far end of the ward and, where possible, there are designated areas for males and females. We were advised that there is currently a proposal to consider adapting the unit to accommodate an enhanced care suite, which would require a change in the number of bedrooms. We were told that, although the unit has had anti-ligature work completed, there are still some ongoing issues, and these should be addressed.

The outdoor space continues to be developed. There were new planters and seating areas for patients, and the area is well used and maintained.

We raised the issue of the front entrance to the IPCU at the end of our visit. There are two doors, one which has the bell and signage, the other – which is the actual door – has an electronic card reader for staff. We suggested that it might be helpful for visitors to the ward to be able to see the correct entrance more easily.

Any other comments

We were pleased to hear about the development of a multi-professional network for staff working in IPCU. We were told that the first meeting has taken place between the IPCU in the Royal Edinburgh Hospital (NHS Lothian), Hollyview Ward at Stratheden Hospital (NHS Fife), and Ward 1 at St John's. There are plans for the network to meet quarterly to look at the standards of care across the units.

Summary of recommendations

Recommendation 1:

Managers should review the pharmacy service regarding input to the IPCU.

Recommendation 2:

Managers should continue to develop a person-centred approached with the intervention and outcome sections of the care plans.

Recommendation 3:

Managers should ensure specified persons procedures are followed in relation to the completion of necessary forms.

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.

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