mentalwelfare commission for scotland

VISIT AND MONITORING REPORT

Intensive psychiatric care in Scotland 2015

A report following a series of announced and unannounced visits to all intensive psychiatric care units in Scotland in 2015

MARCH 2016

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The Commission

What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by:

- Checking if individual care and treatment are lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

Introduction

What is an intensive psychiatric care unit (IPCU)?

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.

Admission to an IPCU should be for as short a period of time as is necessary and patients transferred to a less restrictive environment as soon as possible.

There are no formal national minimum standards for IPCUs in Scotland but national standards in England and Wales have been in place since 2002[1].

This report details what we found when we visited all intensive psychiatric care units across Scotland providing care for adults. It contains recommendations we have made to improve care and we also highlight some good practice we found.

We met and reviewed the care of 119 patients. We spoke to 19 carers, most often a family member, and we also spoke to staff.

Key findings

We found:

- General improvements in the physical environment in IPCUs across Scotland since our last series of visits. Most were of a good or reasonable standard.
- Good access to independent advocacy.
- The majority of carers we met reported that they were consulted and involved in discussions about care and treatment plans.
- Patients were generally not subject to blanket restrictions, and most restrictions were decided on a case by case basis.

[1] Department of Health (2002). Mental health policy implementation guide. National minimum standards for general adult services in psychiatric intensive care units (PICU) and low secure environments.http://napicu.org.uk/wp/wp-content/uploads/2013/04/2002-NMS.pdf

We also found:

- Around a quarter of all patients had been admitted to IPCU for longer than 90 days. Around 10 per cent had been admitted for longer than 200 days. This number was much higher than we would have expected in an IPCU.
- Female patients were more likely to be admitted for lengthy periods of time.
- Delays in some patients moving from IPCU to specialist forensic provision.
- Some patients in IPCU had a primary diagnosis of alcohol related brain damage, acquired brain injury or dementia. Whilst these admissions were not inappropriate, there was often a significant and unacceptable delay in then moving on to appropriate and local longer term care.
- A small number of patients from an ethnic minority reported feeling that they felt discriminated against.
- Around a quarter of all patients reported not feeling safe, and around a half of all female patients who expressed an opinion did not like being in a mixed sex environment.
- Some patients were informally secluded within the IPCU, but without the safeguards of regular review afforded to patients designated as being formally secluded.
- Many staff we interviewed were unclear about the distinction between the terms; seclusion, time out and de-escalation.
- There was a lack of support and discussion for patients who had been subject to a period of physical restraint.
- There was a general lack of awareness about the right of appeal in relation to specified person restrictions.
- Only a small number of patients had made an advance statement and of those who had, very few had a copy of this on the ward.
- There was variable compliance with consent to medical treatment requirements of the Mental Health Act.
- The provision of therapeutic activities can still be improved.

Recommendations

IPCU managers should

- Consider reconfiguration of the physical environment where possible to facilitate female only areas within the IPCU.
- Initiate and/or review their seclusion policy and ensure staff are clear about the distinction between the terms seclusion, time out and de-escalation.
- Provide options so that, where possible, bedrooms are not used for purposes of de-escalation and seclusion.
- Ensure that following an episode of seclusion or restraint, the patient is offered the opportunity to discuss and review the incident with staff.
- Review the training that staff receive in relation to cultural awareness, equality and diversity and encourage staff to take action if they find instances where patients feel discriminated against.
- Audit compliance with consent to medical treatment requirements of the Mental Health Act including the use of as required intramuscular medication.
- Ensure patients are made aware of the right of appeal in relation to specified person restrictions.
- Ensure staff identify on admission if the patient has an advance statement and make sure it is available and highlighted in the care file.

Scottish Government should

- Review the forensic estate in Scotland. This should include, as a matter of urgency, the availability of medium and low secure/step down facilities for women. (This review is underway at the time of writing this report).
- Review, in conjunction with NHS boards, the availability across Scotland of NHS provision for adults with alcohol related brain disorder (ARBD), acquired brain injury (ABI) or dementia who require specialist and intensive ongoing care provision and cannot be safely and therapeutically managed within existing (non IPCU) care settings.

NHS Boards should

- In line with the recommendation in the 2010 overview report; monitor and review length of stay in the IPCU. If a person's stay reaches three months there should be a formal review, involving all those providing care, to consider whether the person's needs continue to be best met in the IPCU environment.
- Review local care provision for those with ARBD, ABI or dementia who require ongoing specialist care provision.

- Actively promote the use of advance statements in anticipation of the new duty for Boards under the Mental Health (Scotland) Act 2015. The 2015 Act introduces a requirement for NHS Boards to keep a copy of any advance statement received with the patient's records, and publicise the support that they provide to make and withdraw an advance statement.
- Support the implementation of the NHS Education for Scotland equality and diversity strategic Action Plan 2013-17, and ensure that all health staff are being given access to learning and resources which enhance their skills and knowledge for delivery of safe, effective, person-centred care for people from minority ethnic communities.

Scottish Patient Safety Programme - mental health

We recommend that this report is considered in relation to the current work programmes to ensure continuous improvements with particular reference to:

- Support and discussion with patients who have been subject to or witnessed a period of physical restraint.
- The use and understanding of seclusion.

What the Commission will do next

- We will continue to visit all IPCUs in Scotland at least once a year.
- We will write to all IPCU managers following publication of this report and ask them to provide us with an action plan in response to the recommendations made. We will review progress made on our annual visits to each IPCU.
- We will share information and work collaboratively with the Scottish Patient Safety Programme - mental health.
- We will regularly review our good practice guidance on seclusion and restraint.
- We will carry out a themed visit in late 2016 to low and medium secure forensic services.
- We will continue to work to promote the use of advance statements.
- We will ask the Mental Welfare Commission equality group to consider further action that the Commission should undertake to address the issue of discrimination within ethnic minority groups.

Why we visited

We visited because patients in IPCUs are likely to be subject to higher levels of restriction than those in general adult mental health admission wards.

We want to make sure that when restrictions are in place that they are used in the least restrictive manner, for as short a time as possible and patients are afforded the safeguards of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Because of the potential restrictions, we try to visit, at least annually, all IPCUs in Scotland. This is part of our local visit programme. We decide when and how often to visit based on what we found at the previous visit, the service's response to any recommendations that we made and information we receive from a variety of sources.

A themed visit is when we visit patients in similar services across a short period of time and have key questions that we want to ask patients, visitors and staff.

We are keen to identify areas of good practice to share across all IPCUs and make recommendations for improvement both locally and nationally, based on the information we collect. We were also keen to see what had changed since our previous themed visits.

Previous visits

We visited all IPCUs as part of a national themed visit in 2000 and in 2010.

In 2000 we visited 17 IPCUs across Scotland, and our main concern then was the poor physical condition of many of the IPCUs.

In 2010 we carried out a series of visits in collaboration with NHS Quality Improvement Scotland (NHS QIS) (now Healthcare Improvement Scotland). *IPCUs, Overview Report June 2010*[2]. NHS QIS staff carried out inspections and census activity and Commission officers interviewed patients on the units.

The key messages from the 2010 report were:

- Everyone in Scotland should be able to easily access an IPCU. Length of stay should only be as long as necessitated by clinical need.
- Everyone in an IPCU should be able to access the support that they need to enable them to recover, including a range of activities, therapies, treatments and inputs from family, friends and carers.
- The specific needs of all people accessing an IPCU should be assessed and mechanisms put in place for people's safe management. Particular attention should be paid to women and younger people who require intensive psychiatric in-patient care.
- Carers should be supported and provided with information that will assist them in their caring role. The needs of carers should be taken into consideration and their views taken into account as much as possible when any decisions about the patient's care and treatment are made.

[2] NHS Quality Improvement Scotland (2010) *Intensive Psychiatric Care Units: Overview Report June 2010* http://www.healthcareimprovementscotland.org/our_work/mental_health/ipcu/ipcu_national_overview.aspx

Part of this work involved taking an IPCU census and at that time there were 14 IPCUs identified with a bed compliment of 147. On this themed visit we visited 15 IPCUs with a bed complement of 138.

This themed visit did not set out to replicate the work done in 2010 though there are some common themes.

How we carried out these visits

We collected information on all the IPCUs (15) in Scotland. A full list of where we visited and the bed numbers in each intensive psychiatric care unit can be found at appendix one.

To help us decide what questions to ask, we consulted with the Patient's Council at the Royal Edinburgh Hospital and Highland Users Group. We thank them for the time they took to help us.

We also asked what they thought we should be looking for and asking about when we visited. The most common themes were:

- Visiting rules.
- Access to food and drinks.
- Activities.
- Access to fresh air – in the unit garden or hospital grounds.
- Importance of availability of both group and individual advocacy.
- Use of blanket specified person provisions.
- Long wait to get back to acute or rehabilitation ward.
- Importance of staff attitude.
- Having a suitable place for children to visit.

There was no particular "IPCU carers" group to meet with, as most IPCUs admit patients on a short term basis, but we did ask the groups we met with what they thought was important for friends and family visiting them.

We developed interview schedules for patients, carers, and staff and also a brief audit tool for the physical environment.

We carried out a pilot visit using these interview schedules in the IPCU at Ailsa Hospital, Ayr. We would like to thank them for their co-operation in allowing us to do this.

We visited each IPCU between May and August 2015. Around six weeks prior to our visit we wrote to each IPCU manager to let them know that we were coming, and to give details of the information that we wanted to collect on the day of our visit.

We provided information leaflets and posters to let patients and visitors know of our intention to visit, and to give them the opportunity to meet us privately either by making an advance appointment or asking us if they could meet on the day of the visit.

There was a maximum of two Commission visitors to each IPCU so as not to over-crowd the environment.

On the day of the visit we met all patients, visitors and staff who wanted to speak with us. We also reviewed the care files and drug prescription and recording sheets of all patients we met.

Following this visit, we sent a brief report to the unit manager highlighting any immediate concerns or good practice that we wanted to identify.

Around six weeks later we visited each IPCU again, this time on an unannounced basis in the early evening. On this occasion we focussed on meeting patients and relatives and did not repeat the previous staff interview schedules and environment audit.

Action taken

We often took follow-up action on the day of our visit, or after the visit, as a result of our findings. We did this on 41 occasions (34% of all visits).

In three cases we gave advice to the patient visited, on the subjects of making a complaint, choosing a named person and obtaining advice from a welfare rights officer. We also gave advice to one relative, advising her to contact advocacy services.

We gave advice to ward staff and hospital managers on the day of our visit on 35 occasions. This was most commonly to raise issues about treatment certificates.

On one occasion, we raised the issue of nursing care plans in one IPCU with Healthcare Improvement Scotland[3].

[3] http://www.healthcareimprovementscotland.org/

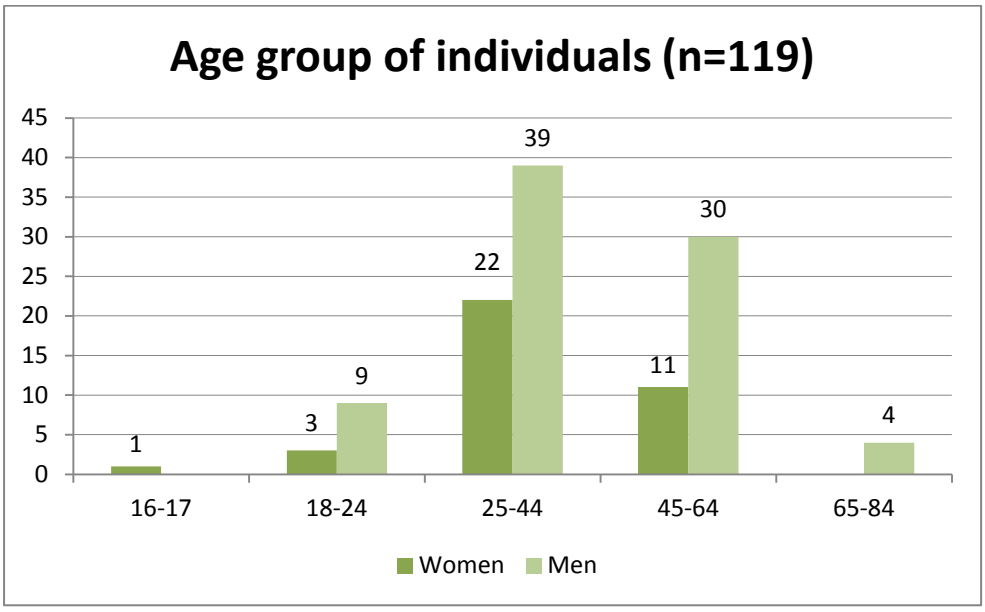
Key information we collected

Age

We met 119 patients and reviewed all of their care files. Some patients were only able to engage for a short period of time with us and we were not able to ask them all the questions we had prepared.

Of those we met, the largest group were aged 25 to 44; around two thirds were male and one third female.

The youngest person we met was aged 16 and we met four people aged 65 plus; the oldest person was aged 74 years.



Detention status

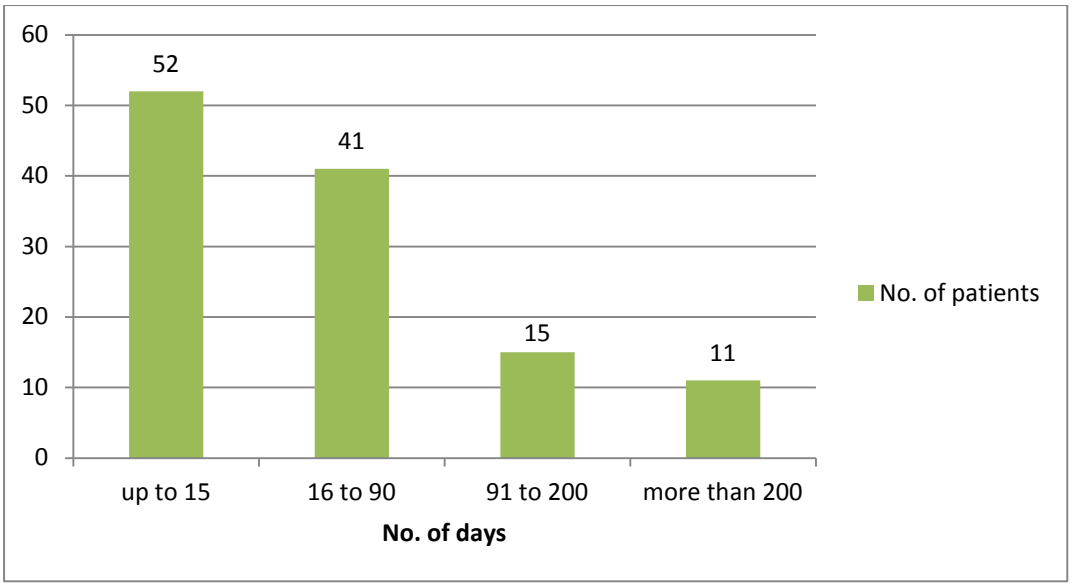
All patients except one were detained, either under the 2003 Act (72%) or the Criminal Procedure Scotland Act 1995 (the 1995 Act) (27%).

The percentage of patients reported detained under the 1995 Act in the 2010 IPCU census was 17 per cent. (Please note, these sets of data were collected in different ways therefore they are not directly comparable).

Of those detained under the 2003 Act, the majority were subject to a compulsory treatment order or interim compulsory treatment order (CTO). Others were on short term detention certificates. (CTO 5 (5), Interim CTO (3), short term certificate (27), cross border transfer (1)).

Of those detained under the provisions of the 1995 Act, these were fairly evenly distributed across the various provisions e.g. transfer for treatment directions, assessment, treatment and compulsion orders.

Length of stay

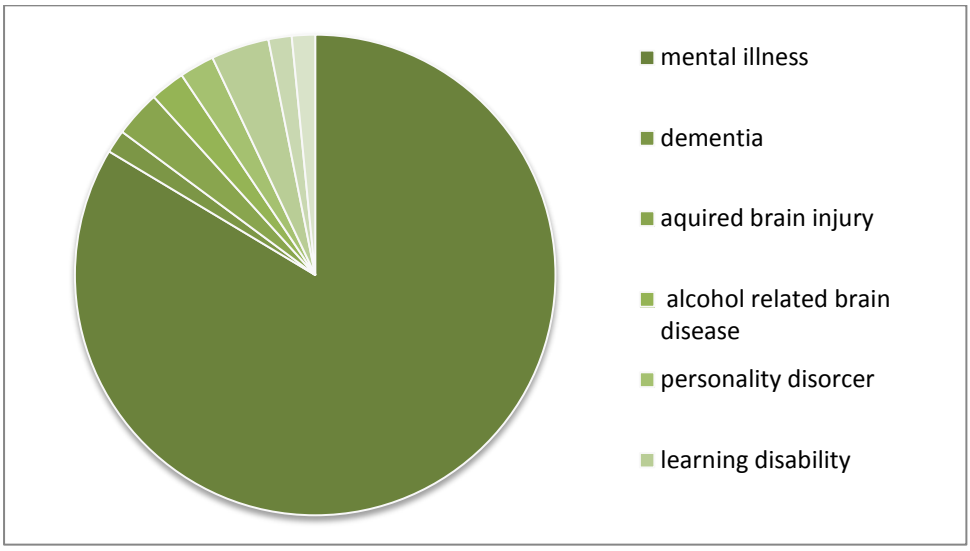


Of the 11 people we identified whose admission had been for over 200 days, six were female. This is concerning given that female patients made up only 31 per cent of the total IPCU patient population.

We examined the care files for all six of these women and found that three were forensic detentions and three under the 2003 Act. All of the women had significant mental illness, and we are following up on these individual cases.

Diagnosis

The majority of patients had a diagnosis of mental illness. Other diagnoses included acquired brain injury, alcohol related brain damage, dementia and learning disability. The numbers below total more than 119 as some patients had more than one diagnosis.



mental illness	107	90%
dementia	2	2%
acquired brain injury	4	3%
alcohol related brain disease	3	3%
personality disorder	3	3%
learning disability	5	4%
autism spectrum disorder	2	2%
other	2	2%

We identified five patients with a mild learning disability; three of these patients also had a diagnosis of mental illness and their admission to IPCU appeared to be appropriate. One patient with a diagnosis of mild learning disability and autistic spectrum disorder was awaiting a specialist learning disability placement at the time of our visit; we have been liaising with his responsible medical officer (RMO) since our visit with regard to delays in this happening.

We identified seven patients with a primary diagnosis of ABI, ARBD or dementia.

Of those with an ABI, one has since moved home with an extensive care package. We were concerned to find that prior to admission to an IPCU, the patient had spent a lengthy period of time inappropriately in a medical ward in general hospital. We have significant concerns about care and treatment during this period and are making further inquiries.

Of the other patients with ABI, one has since transferred to a specialist neurology rehabilitation unit and one was awaiting transfer to a specialist unit but has since died.

Of the two patients with ARBD, one had only recently been admitted from an adult acute ward and the other was awaiting transfer to a specialist NHS unit but this had been difficult and took time to arrange due to a lack of local facilities.

Of the two patients with dementia, one had a vascular type dementia and now has funding secured for transfer to a local independent specialist care service as soon as a bed is available. The other patient has Huntington's disease and has now moved to a specialist independent care service in England.

In all of these cases it was apparent how difficult it was to secure appropriate care once the patient was fit for discharge from IPCU. Smaller Health Board areas in particular described a lack of suitable local resources and were considering moving patients a long distance from their home area (or to specialist provision in England). The age ranges in these cases varied from 35 to 67.

Ethnicity

In this visit we had good representation of people from minority ethnic groups.

Of the 119 patients we met with, 105 patients identified their ethnic origin. Most patients we met with were white British. 5.9 per cent were from minority ethnic groups (Pakistani (3), Chinese (2), African (1), and Caribbean (1).

The number of patients seen (7) from a minority ethnic background were slightly higher than that of the Scottish population. At the 2011 Census the minority ethnic population was four per cent of the total population of Scotland.

The Asian population (Pakistani, Chinese) made up 4.2 per cent of our sample: a larger percentage than the three per cent recorded at the 2011 Census.

All respondents from one ethnic group (Pakistani) reported to us they had been discriminated against; one in general terms and two in relation to their ethnicity.

Of the two who reported feeling discriminated against in relation to their race, one case involved the use of racially abusive language in a ward prior to admission to IPCU and we gave advice on how to pursue a complaint with the assistance of the advocacy service.

The numbers involved here are small but we are concerned that all patients we met with from one particular ethnic group said they had been discriminated against.

IPCU service

Occupancy

Two health boards have recently commissioned a new IPCU in their psychiatric hospital, having had to transfer patients to other areas in the past.

Bed numbers varied from three to 12 with the majority of wards having between eight and 12 beds. All of the wards are mixed sex. The majority of IPCUs were running below full capacity when we visited. Of the 138 available beds, 106 beds were occupied. The exceptions to this were in Lanarkshire, West Lothian and Greater Glasgow and Clyde which were all at their maximum occupancy.

We noted that the number of IPCU beds in some Health Board areas did not appear to correlate with the population of the board area e.g. Forth Valley and St John's.

In some wards with high occupancy, staff reported that patients seem to be staying for longer periods and there is difficulty in transferring to more appropriate hospital accommodation once fit for discharge. This is especially true of forensic patients subject to court orders who are required to remain in the IPCU until authorised by the court to move.

Medical staffing

Some wards have an IPCU consultant as sole RMO. Some have shared responsibility between the IPCU consultant and the host ward RMO and the rest have a host ward RMO responsible for care. Only two wards had input from a forensic consultant.

Occupational Therapy

Most wards have dedicated occupational therapy (OT) sessions and this can include activities on and off ward, in addition to providing functional assessments of abilities. None of the wards have full time OTs.

Advocacy

Access to advocacy is mainly by referral; although three units also have had a regular drop-in service provided which we believe is good practice. The majority of advocacy services respond to requests from patients within 24-48 hours. None of the wards were without access to advocacy for patients.

Pharmacy

Pharmacy staff attend multi disciplinary team (MDT) meetings and carry out reviews of medication, with only one unit reporting no regular pharmacy input.

Staffing

Nurse to patient ratios varied from almost 1:1 to 1:2 at the lowest. However, there is a problem with recruitment and retention in many areas with high rates of bank staff use reported. Senior nursing staff reported spending long periods trying to cover vacant nursing shifts. In one ward, of the seven staff on duty, only three were in permanent posts. In another ward, nearly 75 per cent of staff had only recently been recruited.

Safety and restrictions

What we expect to find

We expect that appropriate measures are taken to keep patients safe and their rights fully respected. We expect that any restrictions are the least restrictive necessary in order to keep the patient safe and to help them feel safe.

Where rights are restricted, this should be in line with the law and good practice.

We expect action is taken to ensure the privacy and dignity of patients who may be subject to enhanced levels of observation, seclusion or restraint.

What we found

Feeling safe

We asked patients if they felt safe on the ward. A majority (71%) said that they felt safe on the ward and a minority (25%) said they did not. We were unable to obtain information from some patients.

We then asked those who did not feel safe if they had reported this to staff. A majority (58%) said that they had reported it. When we asked those who had not reported feeling unsafe about their reasons for not reporting it some of the responses were:

> *"I haven't got round to it yet."*
>
> *"There's no point – nothing would change."*

We asked those who did report feeling unsafe if staff had dealt with their concerns appropriately and around half were happy with staff's response. The most common response from staff appeared to be offering reassurance to the patient.

We asked supplementary questions to the 37 female patients. Half of those who expressed an opinion (25), said they did not mind the mixed sex environment but 12 of the 25 who expressed an opinion expressed some reservations about being on a mixed sex ward.

We also asked if they could go to a part of the ward that was for females only. Around half said that they could, although half of them then explained that they were talking about their own bedroom.

Some of the opinions were:

> *"I initially felt vulnerable but it's alright now."*
>
> *"I would prefer a women-only ward, it doesn't feel as safe having men around."*
>
> *"Does not feel safe all the time. Some patients will be over friendly. She described a few situations when male patients have tried to kiss her, or touch her leg and she has not been comfortable with that."* MWC visitor comment:

We also received a few comments from male patients....

> *"Sometimes would be better single sex, have embarrassed myself when ill."*
>
> *"Women sometimes use the gents' shower, which is annoying."*

Enhanced observation

In 10 of the 15 wards, there were patients subject to enhanced observation; that is, constant or special observation. All of the patients, except one, were detained under the 2003 Act or 1995 Act. (One patient had been transferred to the IPCU without legal authorisation. This was followed up by MWC to ensure that the patient was made aware of their rights).

Twenty patients were subject to enhanced observation on the day of our visits. Of those, 16 were under constant observation; that is, within sight or hearing of a member of staff. Four patients were subject to special observation; within arm's reach of a staff member. Two of the patients subject to enhanced observation had two nurses allocated to observation duties due to an assessed risk of the patient absconding.

The main reasons given by staff for use of enhanced observation were risk to others and impulsive or unpredictable behaviour. Other reasons recorded were: risk of self harm, absconding, suicidal intent, threatening behaviour and vulnerability including one young person in an adult IPCU.

Night-time observations

We asked patients if night-time observations interfered with their sleep. Sixty nine people gave us their opinion on this subject, with most (90%) saying this practice did not interfere with their sleep. Several were clear about why they were being observed at night and that staff looked through an observation window and this did not bother them.

Of those who did report that night-time observations interfered with their sleep, the most common problem appeared to be the use of bright lights or torches.

Use of seclusion

Locking someone in a room alone because of their behaviour is usually referred to as seclusion. The use of seclusion can cause distress and psychological harm and can increase the potential risk of self-harm. It should not be regarded as a therapeutic intervention, but it may be necessary as an alternative for managing extremely difficult situations.

Seclusion can be seen as a form of deprivation of liberty, albeit of relatively short duration. From this perspective, it may be useful to look at ways in which the principles of benefit, least restriction and best interests can be considered alongside a potential infringement of a basic human right.

The Commission's definition of seclusion is that it is 'the restriction of a person's freedom of association, without his or her consent, by locking him or her in a room. Seclusion can only be justified on the basis of a clearly identified and significant risk of serious harm to others that cannot be managed with greater safety by any other means. (MWC, 2014)[4]

Although this definition of seclusion does not include situations where someone prevents a person from leaving a room, for example, by physically blocking the exit, the same principles should still apply in such a situation. This amounts to a form of 'de facto' seclusion. Whilst patients in IPCU will already have been detained under the Mental Health Act, this does not remove their right to freedom of movement around the ward and to other safeguards.

Nine patients were recorded as having been placed in conditions of seclusion during the previous 12 months. Most were for short periods only. In one case where it lasted for more than 24 hours, there was a documented review during each 12 hour period.

In nine of the wards, staff stated they did not use seclusion and had no policy on its use. Three units use bedrooms for seclusion where doors are not locked but staff are deployed beside the door to prevent exit from the room. Some staff said they were aware that this is not an ideal situation. One staff member was unhappy with this arrangement and thought that there should be a dedicated room for this purpose. She was aware that bedrooms contained objects which may increase risk

[4] Mental Welfare Commission for Scotland (2014) *The use of seclusion* http://www.mwcscot.org.uk/media/191573/final_use_of_seclusion.pdf

of injury and recounted one person who had smeared toothpaste on the window into the room to inhibit observation by staff.

In other units, bedrooms are used for de-escalation, where patients are encouraged to remain until calm but are not prevented from leaving. Only one unit has a room which can be used for seclusion but, according to staff, is used for de-escalation only.

We heard from one nurse that they were keen to use environmental means and interventions other than medication wherever possible. This included persuading people to go to their rooms for a period when distressed. However, there was no policy on use of seclusion and staff claimed it was not used. It wasn't clear how patients were persuaded to remain in their room and what happened if the person tried to leave. Without a clear policy on use of seclusion, staff have no way to distinguish between situations defined as de-escalation, time out or seclusion.

There were several incidents reported to us where patients were placed in their room for the purpose of de-escalation and, although staff reported they were free to leave, nursing staff had been posted at the door to the room to carry out observation. Incidents of this type could be interpreted as amounting to a form of 'de facto seclusion', but without the safeguards of regular review afforded to patients designated as being formally secluded.

The National Preventive Mechanism (NPM) are currently developing guidance "to ensure the independent, preventive monitoring of all places of detention and carry out other effective preventive measures". Although, the NPM is not solely concerned with mental health settings, monitoring of use of seclusion will be included in its duties arising from its status as a party to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)[5].

The Commission is assisting in this process by reporting on practice relating to "solitary confinement and isolation" i.e. seclusion across detention settings in mental health facilities in Scotland. The aim is to strengthen the protection of people placed in detention by ensuring their rights are upheld. To do this, there will be an annual requirement for members to assess compliance with specific OPCAT requirements.

The findings from the visits to IPCU wards come at a time that the Scottish Government is undertaking work to bring about change and improvement in patient care which should enhance patient safety within hospitals.

[5] UK NPM (2015) *Monitoring places of detention: Sixth Annual Report of the United Kingdom's National Preventive Mechanism 2014 – 2015.*https://www.gov.uk/government/publications/uks-national-preventive-mechanism-annual-report-2014-to-2015

The Scottish Patient Safety Programme – Mental Health[6] has, as its aim, to reduce harm experienced by people receiving care from mental health services in Scotland. This will be implemented through supporting frontline staff to test, gather real-time data and reliably implement interventions, before spreading across their NHS board area. The work is being delivered through a four year programme, running from September 2012 to September 2016.

The success of the programme will depend upon gradual, sustainable and incremental development of improvement work leading to greater patient safety. The work stream on safety and use of seclusion plans to measure compliance with measures and look at how improvement in outcomes for patients can be made through introduction of training, early intervention and systems of monitoring, debrief and review or practice.

> *"Staff strongly feel they do not seclude, despite the fact that patients can be actively kept from leaving time out room."* MWC visitor comment:
>
> *"She said the staff are very proud of their work with de-escalation, this is a "huge thing".* MWC visitor comment*,* Royal Edinburgh Hospital.

Use of restraint

Of the patients interviewed, 24 had been restrained by staff, either leading up to transfer or after arriving in the IPCU in the previous month, some on more than one occasion. Many had also been administered intra-muscular medication at these times.

Some wards also made use of time out or de-escalation following incidents of restraint to allow for a 'cooling off' period. Only one service had a designated room for this purpose. Other IPCUs used either a 'quiet room' or the patient's own bedroom for this purpose. On only one occasion did we find evidence of staff having tried, or attempted to try, to review the events with the patient at a later time in order to provide an explanation for the staff's stated reason for their intervention.

One patient said that he disliked the term 'time out room', adding that it made him feel like a child.

Most units reported that they were working with the Scottish Patient Safety Programme – Mental Health, seclusion and restraint work stream and were able to report locally on significant reductions in the number of restraints carried out. The Commission welcomes this work and further information about the work being carried out can be found at: http://www.scottishpatientsafetyprogramme.scot.nhs.uk/

[6] http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health

All IPCU staff reported that there was debriefing for staff following an incident of restraint; some had more formal processes than others. We saw little evidence of debriefing or support when we looked at incidents of restraint in patient care files.

We think staff are usually holding a post-incident debrief after a period of restraint but this does not always extend to involving the patient, often at a later time, when they can discuss this. One ward comment was:

> *"No formal process but will be given the opportunity to talk about it on a needs- led basis."* Staff response to MWC visitor question.

We are concerned that such an informal approach is inadequate as there is no clear responsibility as to who would do this and when. An episode of restraint will be distressing for the patient involved. They should be given the opportunity to discuss it honestly and openly with a member of staff and explore possible alternative strategies. Only in this way will it be possible to formulate a care plan to manage stressed and distressed behaviour which takes into account the views of the individual concerned.

Best practice suggests that post-restraint/incident debrief should be conducted with the patient, and include a focus on triggers and psychological harm. An immediate debrief with staff and the patient involved should be held, within three hours, and a formal incident debriefing within seven days, including family and the wider clinical team [7].

> *"The notes describe events where he has 'pushed boundaries'. (No further expansion of what that means in reality). He also attempted to throw himself at a window (all glass is safety glass) and was taken to the quiet room until staff felt it was safe to move him on. The notes do not have any detail about how long that lasted for or any review."* MWC visitor comment:

> *"Piloting two methods of debrief for patients and carers. Do verbal debrief but want to formalise it more."* MWC visitor comment, Gartnavel.

> *"Nursing staff would discuss this on a one to one with the patients present, and with the patient who needed to be restrained. The senior nurse said that the nursing staff, who carry out a procedure, go back to the patient afterwards and relay to the patient the reasons for the restraint*." MWC visitor comment, Inverclyde Royal.

[7] Te Po. o Te Whakaaro Nui. The National Centre of Mental Health Research, Information and Workforce Development, Auckland, New Zealand. (2014) Debriefing following seclusion and restraint. A summary of relevant literature. http://www.tepou.co.nz/uploads/files/resource-assets/debriefing-following-seclusion-and-restraint-281014.pdf

Most IPCUs reported that nursing staff received training that varied in length between two and four days and an annual refresher day. This was usually provided "in house" by a specialist training team and the majority of the training focused on violence reduction, de-escalation and safe management techniques. Training programmes did not appear to extend to post incident debrief and review.

> *"Annual refreshers in control and restraint for staff. They also do de-escalation training, "safe wards" module in-house in IPCU. They have started this in last the six months, planning to make it a rolling programme for IPCU staff. Napier University have asked them to do this for student nurses."* MWC visitor comment, Royal Edinburgh Hospital.

Specified persons

The 2003 Act introduced the concept of "specified persons" in respect of authorising restrictions of an individual's correspondence, use of telephones and also in relation to safety and security in hospitals.

This means that where the RMO is considering applying such restrictions, the patient concerned must be designated as a specified person before:

- Restricting or withholding correspondence.
- Restricting or preventing the use of telephones.
- Taking other measures to ensure safety and security in hospitals (e.g. searching patients and their belongings, taking samples, searching their visitors, restricting access and carrying out surveillance during visits). (MWC, 2015)[8]

Fifteen patients in total were specified persons with appropriate authorisation under s281-286 of the Mental Health Scotland Act in place. However, we found in one instance a patient had restrictions on visitors to the ward but the recorded authorisation was only for restrictions in use of telephones.

In three more cases, mobile phones had been removed without restrictions being authorised. These issues were raised with staff on the day of the visit and followed up afterwards.

Seven patients were specified for safety and security reasons, the main intervention being regular urine screening for illicit drug taking. Fourteen patients were specified

[8] Mental Welfare Commission for Scotland (2015) *Specified Person Guidance: Principles and best practice in implementing specified persons regulations under the Mental Health (Care and Treatment) (Scotland) Act 2003.* http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

for use of telephones, mainly involving removal of mobile phones for inappropriate usage. Four individuals were specified for correspondence, permitting interception of mail items.

Only one patient had requested a review of the specified person status and this was carried out by the RMO. None of the specified patients had requested review by the Commission. We were concerned that this might indicate that patients had not been made aware of their right of appeal under s281-286 of the 2003 Act.

Care planning and participation

What we expect to find

We expect that patients in IPCU are supported to be as engaged as possible in their care and treatment.

We expect that care plans reflect the individual needs of the patient and are regularly reviewed.

What we found

We looked at the care plans in place for patients where possible. We expect to see care plans personalised to the individual and addressing their particular needs.

Of the 111 sets of care plans we looked at, we thought that a minority (28 sets) contained a good amount of individualised content. In the majority (65 sets) we felt that there was a combination of some individualised content and some generic text. In 15 per cent of cases we thought that the content of the care plans was largely generic. Some of our MWC visitors' comments were:

> *"All care plans are standardised with very little that is person-centred."*

> *"Generic care plans, no specific interventions identified."*

We also assessed how appropriate the care plans were to address the individual's needs. We thought the care plans were fully appropriate in a minority (30 cases), partially appropriate in a majority (62 cases) and not appropriate in very few (8 cases).

> *"The patient had very clear and detailed care plans."*

> *"Care plans not dated, not signed, no evaluation except risk of absconding."*

Discharge Planning

We looked at any discharge planning in place for all the 119 patients visited. We could not identify a discharge plan in the notes for around half of patients and we were frequently told that this was because the patient had just been admitted.

Where there was a discharge plan, it was planned to return 21 patients to a general adult psychiatry ward when ready for discharge from IPCU. It was intended to transfer 17 patients to specialist units, such as a medium secure unit or a rehabilitation service.

Plans were in place for 14 individuals to be discharged into the community with support when well enough. Eleven patients were awaiting a court hearing and two patients would be returning to prison.

Advance statements

We were keen to find out how many patients had made an advance statement. An advance statement is a written statement setting out how a person would or would not want to be treated should he or she be unable to make decisions as a result of a mental illness.

Nine patients, around 8 per cent, told us they had made an advance statement. Sixty eight people said that they had not made an advance statement and 23 people could not remember. Four were marked not applicable and for the remaining 15 there was no answer or did not answer.

For the nine patients who had made an advance statement, we checked to see if there was a copy of this document on the ward. We found a copy in only four cases.

> *"Staff were told an out-of-area patient didn't have one. He did have one, within it was that he would prefer not to have Acuphase - he was given some and it had significant side effects."* MWC visitor comment:

Named persons

We were interested to find out how many patients had a named person in place.

We identified 76 patients who had a named person identified. Around two thirds had a named person they had chosen and one third had a named person appointed by default.

For those who did not have a named person, the most common reason was that the patient had chosen not to have one. For some other patients there was no relative or friend who could act in the role of named person.

"Named nurse contacts within 24 hours of admission. Open invite to multi disciplinary team (MDT) reviews, also invited to specific meetings. Information sharing discussed with the patient to obtain agreement about what can be shared. Telephone contact and contact during visiting about any issues or concerns. Generally felt to be good communication." MWC visitor comment, Stobhill.

Documentation of one-to-one sessions with named nurse

We looked at case notes to see if one-to-one sessions with named nurses were being documented. We found these sessions being described in the records for only 44 of the 119 patients (37%). We think that these sessions should be documented to reflect the work being undertaken by patients and nursing staff.

Consent to medical treatment

What we expect to find

We would expect that patients are giving valid consent to their medical treatment or are receiving care under Part 16 of the 2003 Act with the appropriate safeguards in place.

What we found

During our visits we checked that medication being given under the 2003 Act was properly authorised. The usual situation is that either a consent to treatment certificate (T2) or certificate authorising treatment (T3) must be in place for a detained patient once the patient has received medication for two months under the current episode authorised by the Act. A T2 certificate is used where the patient has the capacity to consent to treatment and does so. A T3 certificate is completed by a Designated Medical Practitioner (DMP) in circumstances where a T2 certificate is not appropriate.

We found 55 cases where a T2 or T3 certificate was required. The required documentation was in place for 49 of the 55 patients. This means that six patients did not have the correct authorisation for their medical treatment in place. We also found some instances where only some of the medication being given was correctly authorised under the Act. In total, we brought 15 cases to the attention of ward staff where the treatment was not authorised or only partially authorised.

We also looked at the prescription of "as required" intramuscular medication. Fifty one patients were prescribed this type of medication. We looked at the authorisation for this. We do not think that it is appropriate for this medication to be authorised by a T2 as it highly likely that restraint will be used when this treatment is given and the patient cannot be said to be giving valid consent.

In most cases where “as required” intramuscular medication was prescribed, this was authorised due to the person being within the first two months of treatment, or by a T3 certificate from a DMP. We found three cases where there was no authorisation in place. We also found three examples where this medication had been included on a T2 certificate, contrary to our guidance. We raised these six cases with ward staff during our visits.

Carers and relatives

In this report we use the term ‘carer’ to mean partners, parents, other relatives or friends who provide unpaid care or support to someone. We recognise that some people see themselves as carers while others would not use this term to describe themselves.

What we expect to find

We expect that the carer’s role and knowledge is valued and acknowledged by staff and they continue to be involved in care as appropriate.

What we found

We interviewed a total of 19 carers. We advertised our announced visit in advance and invited carers to make an appointment to meet with us, or to just come along on the day of the visit. At our second unannounced visit we approached any visitors who were in the unit at the time of our visit and invited them to meet with us.

We met with carers across all Board areas with the exception of Forth Valley.

Most of the carers we spoke to (84%) were the parent of a patient in IPCU, with the rest being another family member or partner/spouse. Twenty six per cent of the carers had been living with the patient prior to admission but around half (53%) said they provided direct care to the patient prior to admission.

We asked carers if they were involved in the care planning process. The majority (68%) told us they were. About half were aware of the multidisciplinary team process and of those who were aware; most had been invited to attend meetings. The majority of carers (61%) told us they were involved in discharge planning arrangements.

Finally, we asked if as a carer, they had been offered support and advice and about half told us they had been offered support.

Staff should be making sure that they formally approach carers to ask if they do need any support. This may not necessarily be referral to a formal service but perhaps some extra time with the named nurse or another staff member to discuss how they are feeling and coping.

The general comments we received from carers were positive about the units and the staff. Where we did receive some negative comments, these tended to be about what they considered to be inappropriate placements or delays moving on rather than the care per se.

We met with one carer (parent) who had been upset that, as his daughter's condition deteriorated, he had been turned away from visiting and felt he should have been given more information about the reason for this. Other comments:

> *"I'm quite happy with care and treatment - they keep me informed and they go beyond what they have to do. I trust them and will miss meeting them. They have not written him off - they want to do as much for him as possible."* New Craig's Hospital.
>
> *"Had turned up to visit and been turned away at door, told x too unwell and when asked for information was told they couldn't tell her anything due to privacy. Never been contacted or informed about what's happening."* MWC visitor comment:
>
> *"Has only been in IPCU since yesterday but her sister feels that the atmosphere in IPCU is much better than in the acute admission ward. She said that just coming into the IPCU that evening to visit for the first time her experience had been much better - the nurses were welcoming and were happy to spend time talking to her about how her sister was."* MWC visitor comment, Carseview Clinic, Tayside.
>
> *"No formalised or written programme for this, staff "catch visitors regularly" and talk to them about how things are going. Most individuals will have an organised meeting with medical staff, nursing staff and family during their admission. She said they encourage family to phone and have discussion; medical staff will phone family back."* MWC visitor comment, Royal Edinburgh Hospital.

The physical environment

What we expect to find

We expect an IPCU to provide a safe and therapeutic physical environment that enables the privacy and dignity of patients to be maintained.

What we found

There are a variety of Health Board buildings which house IPCUs, from older Victorian wards to modern newly commissioned units. Most wards were of a good or reasonable standard.

We had significant concerns about the environment in two IPCUs; both are due to transfer to new purpose-built facilities in early 2016.

Most of the bedrooms in the IPCUs visited were modern single rooms, many having en suite facilities. All IPCU wards are mixed sex, though there are significantly more male than female patients. Only two wards have dormitory accommodation.

Most wards were well lit or had good natural light, and furniture and fittings were of an acceptable standard. All had access to garden areas, some being used for patients smoking, where hospitals have not already banned smoking throughout.

Patient safety is of utmost importance in this type of clinical setting. Older wards have particular difficulty in being unable to completely eliminate potential ligature points. However, most wards have regular audits in place to assess potential risk with action plans where necessary.

Many wards have restrictors on windows to eliminate items being passed to patients without knowledge of staff and to minimise risk of patients absconding. Other windows have mesh over the openings fulfilling a similar function.

Some patients can feel vulnerable in a locked ward. Only four of the 15 wards have female-only sitting rooms and only one ward is able to separate the bedroom areas according to gender. In general, staff try to allocate bedrooms to female patients where they are better able to be observed by staff.

Technology can also be used to enhance safety. Four of the wards have CCTV cameras, but these are situated outside the ward, to assist with identification of those seeking to enter or leave.

Individuals transferred to IPCU are frequently distressed or can cause distress in others. Only one ward has a dedicated room for the purpose of de-escalation of a situation when a patient has become distressed or has been causing distress in others. Some wards use other rooms for this purpose. In a number of wards, a sitting room is used. However, in five wards the only option is to use the patient's own bedroom. None of the ward staff stated that there is a dedicated room for use of seclusion.

In seven of the wards, patients have free access to their rooms during the day. In others, there are restrictions to access, managed by nursing staff. Often this was influenced by the physical design of the ward itself and access restricted to enable efficient observation. Where possible, we would expect that patients are able to access their rooms during the day.

Contact with the outside world is important for patients in restricted environments. Few wards have dedicated visiting rooms. However, six have places where families with children can meet with patients. Some of those are situated outside the ward environment and this may be appropriate when young children are visiting. In most

wards, however, visiting takes place in dining rooms, interview rooms, activity space or quiet rooms. Some wards allow visiting to take place in the patients' own bedrooms.

All but one of the IPCUs reported direct access to a garden or outside courtyard space. This IPCU is due to relocate to new accommodation. Of the other IPCUs, eight were reported as being secure and minimising need for nursing staff to accompany patients. The remaining IPCUs reported staff needing to supervise due to security concerns.

When we were planning our visits, we heard how helpful it is for patients to be able to access and store their own food to supplement the hospital diet.

All IPCUs told us that patients could access a vending-machine, hospital shop or off-site shop with assistance as required. When patients are too unwell to go off the ward, all IPCUs said that nursing staff would go shopping for them.

All wards were able to provide storage space in fridges and pantries for patients' own food, but many did say that space in fridges was limited. MWC visitor comments:

> *"Depending on their mental state, people will be able to access local shops by themselves, or with a staff escort if assessed as necessary. If the person is not allowed period of suspension, staff will purchase items for patients."* Argyll and Bute

> *"There is a good enclosed garden area directly off the ward. It is pleasant and well maintained, with a shelter. Mainly used by smokers. Though there is easy access to the ward, staff need to be present for supervision, and this can cause problems if staff are busy on the ward."* Inverclyde

> *"Unit has been through a lot of changes - decanted while refurbishments took place, improving the environment and creating a three bed female unit. Lot of improvement work being led by the senior charge nurse (SCN). Recent feedback from carers identified improvements in environment and culture in wards. The SCN feels this is very positive and feels IPCU is now working in a much more personalised and person centred way. Nascent Scottish IPCU Network is being set up."* Carseview.

Activity

What we expect to find

We expect that an IPCU should provide a range of therapeutic activity and occupation for patients to help with their recovery.

What we found

In 2010 there was a strong theme coming from the patient and carer experience regarding a lack of meaningful and enjoyable activities available in IPCUs. This included lack of access to fresh air and outdoor spaces as well as opportunities to take part in organised, individual and/or group activities.

At this visit, around half of all patients interviewed thought that the range of activities offered to them was good or satisfactory and this does appear to be an improvement on the 2010 report.

There did though, remain a number of patients who thought the activities available to them were sparse or non-existent.

We asked patients about the activities available to them on the ward. Eighty nine people gave an opinion on this subject.

> *"I really like the gym. I want to get passes so that I can jog outside."*
>
> *"I like craft-based activities and I'm currently working on a tapestry."*
>
> *"I like painting and getting out into the garden. I have been enjoying cooking."*

Thirty seven individuals thought the activities available to them were sparse or non-existent. Some comments were heard were:

> *"There's nothing to do."*
>
> *"I've not been offered any activities."*

Eight patients commented that activities were available but they chose not to participate.

> *"There's nothing of interest to me."*

We also asked patients if they were able to go outdoors. Eighty three patients said that they could, while 12 said that they could not. We were unable to obtain an answer to this question from 24 patients.

Whilst improvements have been made, there still remain an unacceptably high number of patients who reported inadequate activity provision. This is concerning as many patients are admitted for an extended period of time.

Conclusion

We have included positive findings and comments within this report and look forward to continued improvements in the care, treatment and support of patients in IPCUs. For some patients though, their continued admission to an IPCU is unnecessary and overly restrictive.

We accept that sometimes an extended period of time in an IPCU is required until they are well enough to return to an open ward environment, but an IPCU should not be expected to provide long term care. For some patients, particularly women, who are waiting for a forensic care setting or have complex conditions such as a brain injury or alcohol related brain damage, their admissions are often unnecessarily long.

When restrictions are placed on individuals at a time of acute illness, their rights must be respected and any interventions should be the least restrictive necessary in order to achieve a safe and therapeutic environment for them.

We have been reassured at this series of visits that staff are increasingly aware of the rights and individual needs of patients, and are making changes to provide individualised and person-centred care in such a potentially restrictive environment. We look forward to this progress continuing.

We would like to thank all patients, carers and staff who took the time to meet us at these visits and share their experiences with us.

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Appendix/tables

Hospital	Total beds
Ailsa	7
Argyll & Bute	5
Carseview Centre	10
Forth Valley Royal	12
Gartnavel Royal	12
Inverclyde Royal	8
Leverndale	12
Midpark	6
New Craigs	10
Royal Cornhill	11
Royal Edinburgh	10
St. Johns	12
Stobhill	11
Stratheden	6
Wishaw General	6
Grand Total	**138**

What we asked patients

Where patients were agreeable to be interviewed we asked:

- What is it like to be on this ward?
- What do you think of the way you are being treated here?
- Is there anything you would like to discuss with us?
- Have you made an Advance Statement and if so we checked to see if a copy was available on the ward.
- Do you feel safe here and if you have felt unsafe, why, if you have not felt safe did you report your feelings to staff and if not what prevented you from doing this. Did staff deal appropriately with your concerns about safety?
- Where female, patients we asked is there anywhere in the unit you can go that is women only.
- Does night-time observation ever interfere with your sleep?
- What is there to do on this ward?
- Are you able to have visitors?
- Is there somewhere private to meet your visitors?
- Are you able to go outdoors?
- We also asked people if they felt they had been discriminated in any way and asked them their ethnic group and asked further questions on this if they identified themselves as not being Scottish/other British.

Information we collected about individual patients

Our visitors collected information about

- The current detention status and diagnosis of all patients.
- The level of observation that the patient was subject to, when this started and the reason for this.
- Individual care plans.
- The range of activities available.
- Specified person provisions including safety and security, correspondence and phones.
- If the patient had been subject to restraint in the last two weeks and we looked at the frequency of this, the date of the last restraint incident, detail of the restraint, sought evidence of review and evidence of discussion and debrief with the patient.
- If the patient had been subject to seclusion in the last two weeks and if so the frequency, the date of the last seclusion incident, where this was recorded, evidence of review and evidence of discussion debrief with the patient.

- Consent to treatment provisions of the Mental Health Act including the necessity for T2 and T3 forms and we checked prescription sheets to see if any other medication that had been prescribed that was not covered by appropriate paperwork. We checked to see if the patient was receiving as required medication and how often.
- Whether one to one sessions with the named nurse were documented.
- Plans for the individual patient to move on from the IPCU.
- Whether there was a named person in place and if not why not.
- If the named person had been chosen by the patient or was default and if there were any issues with sharing information with the named person.

We asked nursing staff

- Details of the ward including the staffing whole time equivalent of qualified and unqualified staff, available beds and occupied beds, numbers of patients on enhanced observation and numbers of detained and informal patients, any current delayed discharges.
- The number of patients in seclusion on the day of our visit.
- Admission and discharge criteria to the ward including pre-admission assessment, any recent unusual admissions e.g. young people, learning disability dementia, post-natal.
- If CPSA patients admitted directly from the court.
- Do they have access to advance statements.
- The RMO arrangements for the ward.
- Who attends multi-disciplinary team reviews
- Access to psychology and number of nursing staff trained in psychological interventions.
- Level of input from occupational therapy, pharmacy, social work, advocacy.
- Activities provided for patients on the ward.
- Were patients able to access a local shop and store own food stuffs.
- How family and carers were kept informed, involved and updated about care and treatment and the general visiting arrangements in place.
- About the rapid tranquillisation protocol.
- We asked about training for staff in restraint and de-escalation and the debrief and reviews that are carried out after incidents of restraint. We asked how patients and any witnesses were given information following episodes of restraint.
- We asked what happens to the information produced by the review of restraint incidents.
- We asked how many episodes of seclusion in the last twelve months and looked at the policy on seclusion. We asked how nursing staff define seclusion and if there was any other form of isolation or confinement in the room. We asked staff for any other comments.

What we asked carers

- To let us know their relationship to the person that they were visiting and their age range.
- To give their account of their current experience of involvement with the IPCU and any issues they wanted to raise.
- If they were living with the patient at the time of admission or if they had regular contact.
- If during this admission their views had been sought or they had been consulted about how the IPCU planned to provide treatment and support for the patient.
- Were they informed about multi-disciplinary team or ward round meetings and if so were they invited to attend.
- If they attended, if they found these helpful and did they have an opportunity to contribute to the discussion.
- About the support or advice that they required as a carer and if so what assistance they have received.
- If they had been consulted about the development of the care or discharge plan.
- We asked if the same situation arose again was there anything they would like to see done differently.


npm
national
preventive
mechanism

mentalwelfare
commission for scotland

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