



Mental Welfare Commission for Scotland

Report on announced visit to: IPCU, St John's Hospital
Howden Road West, Livingston EH54 6PP

Date of visit: 31 March 2017

Where we visited

The intensive psychiatric care unit (IPCU) is a 12-bedded unit on the lower ground floor of St John's Hospital. IPCU is a low secure unit, for mixed gender from ages 18-65 years.

The capacity of the ward had been reduced to six patients only for some time prior to the visit to allow anti-ligature work to be completed.

Patients who are in IPCU are detained under the Mental Health (Care and Treatment) (Scotland) Act 2000 or the Criminal Procedures (Scotland) Act 1995.

We last visited this service on 22 January 2016 and made recommendations about multidisciplinary team input and lack of psychology provision; reviewing the electronic storage of MHA forms; and reviewing the physical environment to address risks. On the day of this visit we wanted to follow up on these issues.

Who we met with

We met with and/or reviewed the care and treatment of all six patients.

We spoke with the service manager, the clinical nurse manager, senior staff nurses and the consultant psychiatrist.

Commission visitors

David Barclay, Nursing Officer and visit co-ordinator

Dr Mike Warwick, Medical Officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit there were only six beds occupied out of a possible 12 as the renovations to remove risk from ligature points meant that the ward capacity had to be temporarily reduced. Managers told us that these works were able to be completed over the preceding six weeks without moving patients out of area or closing the unit completely.

Patients commented positively of their care and treatment in IPCU. They felt as though they were treated with respect by staff who they trusted. We observed respectful interactions between staff and patients. The ward was calm and relaxed.

Multidisciplinary documentation and review

We saw good, comprehensive admission assessments with good medical and nursing input to these. A senior medical review is undertaken within 24 hours of admission, which is good practice.

Staff routinely conduct a risk assessment for each patient during the admission process, including a Sainsbury's Level 2 risk assessment. These had been completed for patients we saw with a high level of detail and a lot of useful, individualised information. However, the risk management plans compiled at the end of these risk assessments tended to be quite generic in content.

We saw some nursing care plans with person-centred content. However, the majority of nursing care plans for mental health issues lacked person-centred content. Interventions sections tended to be limited to rather generic lists of interventions and care. We would expect to see more individualised content, e.g. clear plans for what works best to reassure and redirect the individual if they are distressed or agitated.

In the notes we reviewed, we did not see clear nursing note entries recording one to one sessions in the previous 10 days. These should be specifically highlighted and easy to identify.

The weekly ward multidisciplinary review meeting, and plans from this, are documented on a weekly care plan review pro forma. This is good practice. There is a section for recording who was present by discipline and initial. The list tended to be populated only with ticks. Initials should be added to provide a record of who was there.

There seemed to be a lack of clear process for review of risk assessments and management plans. We had discussion with the clinical nurse manager about this. We suggest that the "identified risks" section of the weekly care plan review document could be developed with prompts for reviews of risk assessments/risk management plans to be undertaken when indicated.

Recommendation 1:

Managers are to ensure that all nursing care plans are person-centred and contain individualised information, reflecting the care needs of each person and identifying clear interventions and care goals. These should be regularly reviewed and evaluated.

Recommendation 2:

Managers should review processes for review of risk assessments and risk management plans, and the documentation of this.

Multidisciplinary team input

On the ward there is an occupational therapist (OT) and OT technician who carry out specific individual assessments and deliver the appropriate therapy and activities on and off the ward. This service is available five days per week. We observed the interaction of the OT and later met with them to discuss their input. The patients we spoke with were complimentary about OT input but some were dissatisfied with the variety of activities on offer in the ward. We were informed that these are reviewed weekly and patients have a choice form to complete that enables the most popular activities to be offered each week.

Access to psychology is by referral only. Senior staff told us that the ward still does not have any dedicated psychology resource for direct work with patients, staff training in psychological therapies or supervision. They told us that the lack of dedicated psychology input is affecting patients' ability to progress through the unit to discharge. We will escalate this issue to managers as it has not been progressed since our last visit.

Recommendation 3:

Managers should urgently review the need for dedicated psychology provision for patients in IPCU.

Use of mental health and incapacity legislation

We checked whether patients detained under the Criminal Procedures Act or the Mental Health Act had a 'consent to treatment' (T2) or 'certificate authorising treatment' (T3) form in place to authorise medication where a form was required. The following refers to these patients.

One patient had a T2 form authorising psychotropic medication. They were also prescribed intramuscular (IM) 'if required' psychotropic medication that was not covered by a T3 form.

We agree that IM 'if required' psychotropic medication should not be included on a T2, as it is likely that the patient would not be consenting to receive this if it was later administered. If this medication is prescribed, we consider that a T3 form should be in place to authorise this. We discussed this with the senior staff nurse on the day and also the responsible medical officer (RMO).

We advise that, if IM 'if required' psychotropic medication is not authorised on a T3, this should not be prescribed prior to circumstances arising where this may be needed. A medical review should be arranged at that time. The doctor can then consider whether the grounds are met for urgent treatment under s243 of the Mental Health Act.

Another patient who required a T2 or T3 to authorise medication did not have a form in place. They had received treatment outwith the authority of the Mental Health Act for some months. They had only recently been admitted to IPCU and come under the care of their current RMO. The RMO had identified this issue and requested a visit by a designated medical practitioner (DMP). We advised the RMO to inform the patient of treatment they had received outwith the Act.

We consider that processes need to be developed to ensure that medical staff determine on admission whether a patient requires a T2 and/or T3 form to be in place. If so, they should establish whether they have a T2 or T3, and what this authorises, and be clear that there is no authority to prescribe other psychotropic medication, unless this is urgent treatment falling within the provisions of s243 of the Mental Health Act.

Recommendation 4:

The RMO must ensure that prescriptions of medications for detained patients are properly authorised, with a T2 or T3 form in place where this is required by the law. Medical staff should prescribe within the law from the point of admission.

Rights and restrictions

IPCU is a locked ward and requires a swipe card for entry and exit. Patients who have agreed time out as part of their care can ask staff to let them out of the ward. There is an outdoor courtyard area that patients can use if they do not have any time out.

We found appropriate use of 'specified persons' legislation. Where patients were specified persons, this was recorded in the care file and they were given written information detailing their right to request a review.

We saw that there was no specific seclusion room available in IPCU. Staff told us that patients are nursed under close observation in their own bedrooms if needed. There are debriefing sessions following episodes of this management and these are recorded in the care files. The team are looking into developing a de-escalation suite. We suggested that, in the meantime, consideration might be given to installing an appropriate mirror in a room to be used for this purpose to allow all parts of the room to be seen through the observation window (as was done in the IPCU at the Royal Edinburgh Hospital).

The physical environment

All 12 bedrooms are ensuite with a shower, basin and toilet. There is a shared bathroom for both male and female patients. The ward had just completed anti-ligature improvements. All 12 bedrooms and their ensuites have been updated and are now anti-ligature; all handles on doors have been changed to provide a safe and secure environment.

The senior manager for the mental health services informed us that the ligature works were just being completed on the morning of the Commission visit. We were able to see one of the empty rooms that had been renovated to a very high standard. This work has to be carried out through all the mental health wards at St John's Hospital; IPCU was completed as a priority.

The ward has a therapy room which is used for individual group therapy and cooking groups. There is also a pool room available on the ward which is well used.

There is access from the ward to an outdoor courtyard; this is an enclosed area that is safe for patients to access. This area is rather bleak and unwelcoming. There are plans to upgrade the soft asphalt covering the ground as it is damaged in some areas. Managers are seeking funding to do this. We think that this should be done, and other work should also be planned to freshen up the environment in the courtyard. We look forward to seeing how this has been progressed at future visits.

Recommendation 5:

Managers should take forward work to improve the environment in the IPCU courtyard.

Summary of recommendations

1. Managers are to ensure that all nursing care plans are person-centred and contain individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.
2. Managers should review processes for review of risk assessments and risk management plans, and documentation of this.
3. Managers should urgently review the lack of dedicated psychology provision for patients in IPCU.
4. The RMO must ensure that prescriptions of medications for detained patients are properly authorised, with a T2 or T3 form in place where this is required by the law. Medical staff should prescribe within the law from the point of admission.
5. Managers should take forward work to improve the environment in the IPCU courtyard.

Good practice

We particularly liked that all patients have a senior medical review within 24 hours of admission to IPCU.

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

Mike Diamond

Executive Director (social work)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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