

Mental Welfare Commission for Scotland

Report on announced visit to: Royal Edinburgh Hospital,
Intensive Psychiatric Care Unit (IPCU), Morningside Terrace,
Edinburgh, EH10 5HF

Date of visit: 26 April 2016

Where we visited

The Intensive Psychiatric Care Unit is a 12-bedded unit. It has three single bedrooms for women and nine for men. It is the IPCU for Edinburgh, Midlothian and East Lothian.

The ward is to be relocated to a 10-bedded unit in the new Royal Edinburgh Hospital, which is currently being built. It is expected that the move will take place at the beginning of February 2017.

On the day of our visit there were eight patients, all of whom were detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the mental health provisions of the Criminal Procedures (Scotland) Act 1995.

We last visited this service during our series of announced and unannounced visits to all IPCUs in Scotland in 2015. We conducted an announced visit on 24 June 2016 and an unannounced visit on 13 August 2015.

After those visits we gave local feedback about:

- communication with relatives and carers
- need to develop procedures for debriefing of patients after restraint or seclusion
- our concerns about the use of regular bedrooms for seclusion
- the number of episodes of use of seclusion being quite high at that time

We recommended to managers that they review the need for a specifically designed seclusion room. There now is a specific de-escalation room in IPCU.

We recommended to managers that they undertake a review of the use of seclusion in IPCU. This was done.

Our national report from these our to IPCUs in 2015 is available on our website: http://www.mwcscot.org.uk/media/315618/intensive_psychiatric_case_in_scotland_report_final.pdf

On the day of this visit we wanted to follow up on our previous feedback and recommendations.

Who we met with

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

We spoke with the director of operations; acting chief nurse, interim clinical nurse manager, clinical services manager, senior charge nurse and consultant psychiatrist. An independent patient advocate from AdvoCard supported three patients during their meetings with us.

Commission visitors

Dr Mike Warwick, medical officer (visit coordinator)

Mary Leroy, nursing officer

Margo Fyfe, nursing officer, attended meetings with staff on the morning of the visit.

What people told us and what we found

Care, treatment, support and participation

All interactions towards patients we observed staff having were warm, friendly and supportive. We heard positive comments about staff from some patients we met. When we discussed patients with staff they were knowledgeable about them as individuals. One man particularly said that he has 1:1 sessions with nursing staff, and that these are sometimes initiated by staff and sometimes by him. We saw documentation of 1:1 sessions in patients' notes.

Some people raised individual issues about their treatment or being in IPCU. We offered them advice on their rights. We followed up some issues people raised with us with staff. One patient had recently made a number of complaints about their treatment. NHS Lothian are looking into their concerns. We have asked managers for a copy of their response when it is available.

Multidisciplinary team (MDT) documentation, risk assessments and reviews

We saw good assessments undertaken by staff on admission, including completion of Sainsbury's risk assessment and management proformas by nursing staff and medical examinations. Daily notes were clear. We saw evidence of physical healthcare and investigations. Stickers recording individual episodes of use of 'if required' psychotropic medication were placed in the daily notes and easy to find.

We suggested that nursing staff may find it helpful to write notes with an approach such as SBAR (situation, background, assessment, recommendation). Nursing staff elsewhere have told us that they find this helpful for care planning.

The IPCU consultant psychiatrist provides care for patients in IPCU, although their consultant psychiatrist on their 'host' ward remains their responsible medical officer (RMO).

An MDT review meeting is held weekly. This is attended by nursing staff, consultant psychiatrist, trainee doctors, occupational therapist and pharmacist. Other staff attend as appropriate on an individual basis (e.g. the patient's mental health officer, staff from their host ward).

New documentation for the MDT meeting has been created which includes nursing review and a record of the ward round discussion. An attendance list will be added.

The proforma includes risk assessment review. There are sections for holistic review under a number of headings. We found that staff had completed this to a high standard, and had documented very comprehensive weekly MDT reviews. These included documentation of physical healthcare provided and activities engaged in. This is good practice.

Nursing care plans

Individual nursing care plans were in place to meet needs and manage risks. All notes we looked at contained care plan(s) for mental state. Care plans we saw were person centred. This is good practice. Some were highly individualised throughout to meet particular needs. Some others contained a good amount of person centred information in the needs section, but mainly generic descriptions of care to be delivered. Some of these care plans could be improved with more person-centred content, e.g. about what works best to re-direct and calm the individual if they are distressed.

Where care plans had been reviewed, this was indicated by the care plan having been re-written, or by a date on the current care plan. We did not find records of summative evaluation and review of individual care plans.

Recommendation 1

Managers should develop procedures for staff to increase person-centred content of care plans and undertake summative evaluation and review of these.

Engagement with carers and relatives

The senior charge nurse said that family can phone nursing staff for updates any time, and they are informed that the Consultant Psychiatrist is available on Fridays. The weekly MDT structured review of care includes a section for engagement with carers and relatives.

Advocacy

Patients are well supported by individual patient advocates from AdvoCard. Group advocacy is provided by the Patients Council.

Prolonged admissions to IPCU

A number of people have had prolonged admissions to IPCU in the past year, including some people awaiting places in specialist facilities out of area.

We are aware that NHS Lothian continues to consider opening new hospital unit(s) that could meet the needs of such patients. We would like to be kept updated on this.

Restraint and Seclusion

There is good emphasis on person-centred care and de-escalation in IPCU. Levels of physical restraint are low.

After our last visit on 13 August 2015, we raised concerns with managers about the use of regular bedrooms for seclusion. We asked them to review this. We were pleased on this visit to see the dedicated de-escalation room that has been created. This has a high-level mirror system to allow the observing nurse to see the whole room through the observation window. It is good to hear that the new IPCU will have a purpose built de-escalation suite. We look forward to seeing this in due course.

After our last visit, we also raised with managers unusually high numbers of episodes of seclusion, and numbers of individual patients secluded. The regular IPCU consultant psychiatrist had been on leave. After his return, he undertook an audit of seclusion. There had been increase in use of seclusion in July and August 2015. He reviewed aspects of the implementation of the seclusion policy and made some amendments to the 'notification of seclusion' form.

On this visit we had discussion with the consultant psychiatrist about these matters. He said that use of seclusion reduced after the peak we highlighted last year, and lengths of episodes of seclusion also reduced. He said that increased use was necessary in February 2016, and this has reduced again. Senior staff are closely involved in reviewing individual episodes of seclusion. The consultant psychiatrist is seeking to reduce the timescale in the seclusion policy for attendance of a senior doctor (currently after 12 hours of seclusion). He said that there are issues to be discussed regarding this, involving availability/rotas. We hope that this can be resolved and that the proposed changes to the seclusion policy can be implemented. We agree that this will be beneficial for patient care.

The service continues to audit seclusion (currently three monthly). The consultant psychiatrist has said he will send the Commission these audit reports.

One patient told us that staff treated them well when they were in seclusion, and that they found this relaxing, but they did not like staff observing them through the window.

Another patient expressed concerns about events during seclusion. This is part of the complaint they have made that we have referred to above. We have asked NHS Lothian for a copy of their response. We saw evidence in their case notes of comprehensive documentation of the decision to use seclusion, their care during seclusion, and review of this by nursing and medical staff.

Debriefing after restraint or seclusion

We asked about procedures for debriefing patients after episodes of seclusion or restraint. The senior charge nurse said that staff discuss what has happened with the patient and document this in their notes. Staff support patients who have witnessed

events, but there is no formal process for debriefing them. She said that they are working on developing systems for debriefing patients after seclusion or restraint, and documentation of this.

Recommendation 2

Managers should progress developing systems for debriefing patients who have been restrained or placed in seclusion, or who have witnessed such management of others, and documentation of this.

Smoking

Three patients expressed unhappiness to us about aspects of the smoking policy. We advised that these are matters for NHS Lothian to manage and develop policies about.

Smoking cessation advice is available, and nicotine replacement therapy can be prescribed. Patients can use disposable e-cigarettes in the garden (these can be prescribed for them). We were told that it is planned to commence regular smoking cessation meetings in the ward.

Use of mental health and incapacity legislation

Mental Health Act – consent to treatment (T2) and certificate authorising treatment (T3) forms

All detained patients whose prescriptions we reviewed had a ‘certificate authorising treatment’ (T3) form in place authorising all medication they were prescribed under the Mental Health Act. This is good practice.

Specified persons

One patient we met had been made a specified person for safety and security under section 286 of the Mental Health Act. This was to authorise supervision of visits from an individual who the consultant psychiatrist was concerned would bring in a dangerous item. This is good practice.

The same patient had previously been a specified person for use of telephones under section 284 of the Mental Health Act. Staff said that the consultant psychiatrist had reviewed this, and he was no longer a specified person for telephones. There was no copy of the consultant’s opinion that he need no longer be a specified person for use of telephones filed with the specified persons paperwork in his file or on TRAK (computerised records). To do this would be good practice. A RES 2 form can be used by the RMO to record their review of the reasoned opinion.

In the section ‘Rights and restrictions’ below, we have commented on a situation where we thought that the consultant psychiatrist should be asked to review a patient and consider the need for use of specified persons procedures.

It should be noted that the patient's RMO requires to give the reasoned opinion that determines that they will be a specified person, unless the hospital managers have appointed another approved medical practitioner (AMP) to do so. The hospital managers can do this under Section 230(3) of the Mental Health Act.

Mental Health Act paperwork administration

Staff said that paper copies of detention papers are no longer kept in case notes as they are on TRAK. We saw an IPCU Mental Health Act information sheet in one patient's notes that was blank. Managers should ensure that staff complete Mental Health Act information sheets.

Rights and restrictions

Searching

We advised managers that the consultant should consider making a particular patient a specified person for safety and security in hospitals under section 286 of the Mental Health Act to authorise searches. Specified persons procedures provide the appropriate framework for review of the restrictions and the patient with their right to appeal against these.

Activity and occupation

Two occupational therapists (OTs) provide input to the ward. A recreation nurse for the ward was due to start on 2 May 2016. The post had been vacant for a few months. We were pleased to hear of this appointment.

We saw thorough OT assessments of individuals' strengths and limitations, and activity checklists.

The OTs undertake individual and group activities, including running a coffee morning. They provide kitchen assessments and support patients with art work.

Patients can access an art room and games room with a snooker table and gym equipment next to the main ward. Nursing staff also support individuals with activities, and escort people on passes within the hospital or suspension of detention. Patients can attend activities at the Hive, which is an activity centre within the Hospital run by the Scottish Association for Mental Health (SAMH).

One patient said that they were bored, and that there was a lack of paint, paper and brushes for the art group. They said that they had been involved in ordering materials. The senior charge nurse also mentioned the need to buy art materials, and that managers are taking forward obtaining funding for this. We hope that the necessary materials have now been obtained.

The physical environment

The ward not built for purpose, but effort has been made to make the best of the accommodation available. The move to the new unit in February 2017 will be very beneficial for patients and staff.

Part of the complaint made by a patient as referred to above was in regard to cleanliness in the ward. The environment is rather tired in places, but we did not note that any areas we saw were dirty. The senior charge nurse explained that some cleanliness issues had been addressed and improved by the domestic staff. Some painting was being undertaken while we were there.

There was been considerable investment to address ligature risk and install ligature safe fittings and anti-barricade bedroom door surrounds relatively recently. It is good that a three bedroom separate female area is available, and also a female only lounge. The enclosed courtyard garden is used by patients. We have referred above to the creation of a dedicated de-escalation room.

There are no issues regarding the environment that we wish to make recommendations about at this time.

Summary of recommendations

1. Managers should develop procedures for staff to increase person-centred content of care plans and undertake summative evaluation and review of these.
2. Managers should progress developing systems for debriefing patients who have been restrained or placed in seclusion, or who have witnessed such management of others, and documentation of this.

Good practice

Staff have used the new 'Structured review of care' documentation to provide clear and detailed documentation of the weekly MDT review meeting. This provides an excellent, holistic review of care and updated risk assessment.

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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