Mental Welfare Commission for Scotland

Report on unannounced visit to: IPCU (Ward 1), Forth Valley Royal Hospital, Stirling Road, Larbert, FK5 4WR

Date of visit: 21 November 2019

Where we visited

Ward 1 at Forth Valley Royal Hospital is a 12-bedded, mixed-sex intensive psychiatric care unit (IPCU). On the day of our visit there were seven patients on the ward, all of whom were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 ('The CPA').

An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

We last visited this service on 8 November 2018 and made no recommendations.

Who we met with

Our visit on this occasion was unannounced, so patients, relatives, and staff had no prior notification of our arrival, and so did not have the opportunity to plan for contact with, or arrange appointments with us. We met with and/or reviewed the care and treatment of seven patients. We spoke with the senior charge nurse (SCN), nursing staff and other ward staff.

Commission visitors

Tracey Ferguson, Social Work Officer

Margo Fyfe, Nursing Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

All the patients we spoke to during the visit told us that they were receiving good care and treatment within the ward. They described the staff as approachable and supportive. Patients told us that they meet regularly with staff to discuss their care needs and feel that staff listen to them.

Staff were knowledgeable about patients when we discussed their care. Risk assessments were thorough, detailed and regularly reviewed. We saw care plans which were detailed and had been reviewed regularly with some evidence of patient involvement. The care plans were primarily based on risk and did not always include holistic needs of individuals. We discussed this with the SCN and acting clinical nurse manager and recommended that a review of the care plans was carried out to ensure the plans are person-centred and cover all of the individual patient's needs.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found here:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We saw evidence of physical care needs being addressed and involvement and links with other specialist practitioners where the patient required this.

We heard that the multidisciplinary team meetings (MDT) were held twice weekly, and we saw detailed recording of these meetings with clear outcomes and goals. It was difficult to see who always attended these meetings as this was not always recorded. We discussed the with the senior charge nurse on the day.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests and that person is called a named person. Some patients had nominated a named person and a copy of this was found in their electronic file.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. Where a patient had made an advance statement we found a copy of this in their electronic record.

Following our previous visit to the ward, we had been informed by managers that the provision of psychology services was being extended to allow greater access across the mental health units. We were told that this did happen however following appointment the individual withdrew and unfortunately this has led to further delay in the recruitment process. We were told that the post has now been filled.

We were told that occupational therapy (OT) provision to the ward is limited, due to staffing issues. This was a concern as there were patients on the ward we were told would benefit from OT input.

Recommendation 1:
Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the holistic care needs of each person and identifying clear interventions and care goals.

Recommendation 2:
Managers should review the provision of OT to the ward to ensure it is adequate to meet the needs of patients.

Use of mental health and incapacity legislation

On the day of this visit, all seven patients were either subject to the Mental Health Act or the CPA.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Patients' electronic records contained the appropriate legal paperwork. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order as appropriate.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

On our visit there were two patients who were made a specified person. From reviewing the file we found the relevant paperwork was not in place and no evidence of reviews and we discussed this with the senior charge nurse on the day. Where a person has been made a specified person they Rae given clear information about this and made fully aware of their right to ask for review of this status.

Our specified persons good practice guidance is available on our website at:

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

Recommendation 3:
Managers should ensure specified persons procedures are implemented for patients where this is required and that the relevant paperwork in completed and reviewed.

Rights and restrictions

The ward is an IPCU and operates a locked door policy. Patients have access to an enclosed garden space. There is a no smoking policy across the site, and patients are offered nicotine replacement options as an alternative.

Where a patient has a history of alcohol and substance misuse, staff will carry out random urine sampling with the patients consent. It came to our notice that patients did not fully understand their rights in relation to this. We discussed the importance of ensuring patients understand their rights and where a patients lacks capacity to consent to testing then specified person status should be used.

We were told that the ward has good links with the advocacy service and patients told us that their advocate supports them in meetings and meets with them regularly.

The Commission has developed *Rights in Mind.*

This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were told that there are two activity co-ordinators that provide morning and afternoon activities to the IPCU and we saw a timetable of activities displayed in the ward.

Ward staff also support patients with time off the ward and we saw this on the day of our visit. Patients told us that they enjoyed time off the ward and we were able to see this was reviewed regularly and progressed where appropriate.

Patients told us that they enjoyed the activities and we saw nursing staff engaging in a range of activity with patients on an individual basis. Pet therapy visits the ward every Monday and patients have access to a pool table, console games and table tennis table. Physiotherapy can support the patient to access the small gym that is a shared facility across the mental health wards.

Organised activities are currently not carried out in the evenings or at weekends and the SCN and acting clinical nurse manager are looking at how to expand the activity provision throughout the week. We look forward to hearing how this has progressed when we next visit.

The physical environment

The ward comprises 12 single bedrooms, and six bedrooms are en suite. There is a communal living and dining area as well as an activity room and small meeting rooms. Soft furnishings have been purchased within the communal areas which reduces the clinical appearance and provides a more homely environment for patients. There is an enclosed garden that the patients can have access to from the ward.

Any other comments

We were told that bank nursing staff are currently being used, although there is a regular group of bank staff who cover the ward.

We were told on the day of our visit that some patients are spending a longer period in the IPCU than necessary. On the day we visited, four of the patients had been identified as no longer requiring to be in an IPCU ward but wards they were due to be transferred to were at full capacity.

The Commission is aware there are a number of discharges that have been delayed across the service which is impacting on discharge and transfer to another wards. We are keen to hear further from managers about how this situation is being managed and will write to them to seek an update on this matter.

Summary of recommendations

1. Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the holistic care needs of each person and identifying clear interventions and care goals.
2. Managers should review the provision of OT to the ward to ensure it is adequate to meet the needs of patients.
3. Managers should ensure specified persons procedures are implemented for patients where this is required and that the relevant paperwork in completed and reviewed.

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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