Mental Welfare Commission for Scotland

Report on announced visit to: Intensive Psychiatric Care Unit (IPCU) University Hospital Wishaw General, 50 Netherton Street, Wishaw ML2 0DP

Date of visit: 30 August 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face-to-face visits; however, this local visit was able to be carried out face-to-face.

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

The Intensive Psychiatric Care Unit (IPCU) is a six-bedded facility in University Hospital Wishaw General. The ward admits both males and females, and provides a separate sitting room for the women. Beds are single rooms with each room having its own end-suite wet room.

We last visited this service on the 25 February 2020, and made the following recommendations; about care planning, the need for the ward to have a seclusion policy, and psychology and pharmacy input into the service.

Who we met with

We met with and reviewed the care and treatment of four patients, and we met with one relative.

We spoke with the service manager, senior charge nurse (SCN), consultant psychiatrist, lead psychologist and other clinical staff.

Commission visitors

Mary Leroy, Nursing Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit the ward was calm. Staff told us there is a recognition this is not always the case and depends upon the patient population at any given time. Patients seemed comfortable in the company of staff and happy to approach them.

The IPCU use Midis as their electronic record system; we discussed the plans for the new electronic recording system Morse, and there are plans to migrate to this system in the autumn.

Patients we spoke with were generally positive about the care and treatment they received in the IPCU, they described feeling safe and listened to.

We spoke with one relative who was very positive about their contact with the medical and nursing team. They spoke about appreciating regular updates from the consultant psychiatrist and felt included in their relative's care and treatment. The relative also spoke about the interactions with the nursing team as being supportive especially during times when visiting was restricted.

Care planning

On a previous visit we had made a recommendation regarding the need for improvement to nursing care plans, particularly the review process. We reviewed individual patient files on the electronic system. We were pleased to see that care plans were detailed and person-centred with good information about specific interventions to meet the identified needs. There was clear identification of needs agreed goals and interventions. We were pleased to see improvements to the reviewing of the nursing care plans, the review process was detailed and linked well with individual goals and interventions within the care plans. This information and the identified actions from the multidisciplinary team meeting (MDT) ensured a clear narrative of the patient care journey.

Risk assessments were detailed, regularly reviewed, and updated. We were also told of the plans to review the risk assessment process. There is a small working group who are focussing on this at present.

Multidisciplinary team meeting/ input

The documentation of the MDT meeting is detailed and provides a good record. The MDT meetings are held on a weekly basis. The multidisciplinary input into the unit is from nursing, medical and occupational therapy. All other allied health professional input can be accessed via referral. The clinical decisions that occur during those meetings are clearly documented and generate an action plan with outcomes and treatment goals. The MDT meetings also evidence patient involvement and attendance. Some patients we met with spoke about their involvement in the decision-making process.

We also discussed the MDT template which has been developed in the IPCU which is now being reviewed and updated by a short working group. On completion, this MDT proforma document will be rolled out across the wider mental health services.

On our previous visit we discussed the input of psychology and pharmacy into the unit. We were pleased to hear our recommendation for psychology for the ward has been supported and funding has been made available. A psychologist has been employed for the ward and is due to commence in Sept 2021.

On our visit we met with the lead psychologist. We discussed the role of psychology in the IPCU: the value of formulation to support the care and treatment of patients with complex needs; the delivery a number of evidence-based therapies; the role of psychology in education training and support to the wider clinical team.

On discussion with senior management regarding pharmacy input, we were informed that a business case has been presented and they awaiting the outcome of this. We understand that at present pharmacy staff are responsive to requests for assistance; however they do not attend the unit regularly, or carry our medication audits on a regular basis, or are able to attend the MDT meetings.

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

Use of mental health and incapacity legislation

On the day of this visit there were five patients within the unit, all of whom were subject to the Mental Health (Care and treatment) (Scotland) Act 2003 ('the Mental Health Act').

All paperwork relating to the act was filed appropriately and easily accessed. For those patients subject to compulsory treatment, we checked whether consent to treatment certificate (T2) and certificates authorising treatments (T3) were in place where required

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

On review of the file of two patients were specified persons, there was evidence of a reasoned opinion.

Our specified persons good practice guidance is available on our website at: https://www.mwcscot.org.uk/node/512

Rights and restrictions

On our last visit to the service, we were informed there was no seclusion room in use and that patients are nursed on higher levels of observation in their own room when they are distressed and require privacy to respect their dignity. Following this visit we made a recommendation on the need for a seclusion policy to be put in place to reflect any restrictions that restrict patient movement. We were pleased to see and review this draft policy. We were told it is now awaiting ratification.

The IPCU is a locked ward and has a "locked door policy", which is proportionate with the level of risk being managed within an intensive care setting.

On the day of our visit there were two patients who required additional support with enhanced levels of observation from nursing staff. We were told that patients who were subject to enhanced observations are reviewed daily. The clinical team discuss the patients care and treatment to determine whether the patient's observation level can be safely reduced. Patients are encouraged to participate with this process.

All patients have access to advocacy. The patients we spoke to were aware of their rights to legal representation. Nursing staff provide contact details of lawyers and opportunities for patients to meet with their legal representatives.

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

Patients and staff told us that activities mainly occur on a one-to-one basis due to the acute level of illness. Nursing and occupational therapy staff provide a range of activities including therapeutic activities, assisting patients understand their illness, recreational /skill development such as cooking and kitchen skills. There is a small room with some gym facilities.

The physical environment

The IPCU unit is situated on the basement level of a busy district general hospital. The unit is clean and bright. The bedrooms are all en-suite, there is a communal sitting area, a female only sitting room, and an activity/ relaxation/ gym room. There is enclosed garden space. This area is well planted and provides a calm outdoor space for patients, it is much appreciated. There is also access to a family room situated outside the ward entrance.

On the day of our visit, many of the patients raised their concerns about the window covering in the bedrooms. There are no blinds on the bed room windows; instead there is an opaque plastic covering on the glass, with exception to a small area at the bottom of the window. Patients commented that it was both oppressive and restrictive as it obscures both natural daylight, and for some the views of the garden. Patients commented on the impact on their

privacy and dignity. On discussion with the SCN we heard that this refurbishment work had been identified, although there is no plan when this will be undertaken.

Recommendation 1:

Managers should ensure that an environmental audit of the window coverings in the bedrooms is undertaken as soon as possible, and refurbishment work is completed thereafter.

Summary of recommendations

1. Managers should ensure that an environmental audit of the window coverings in the bedrooms is undertaken as soon as possible, and refurbishment work is completed thereafter.

Good practice

We discussed the Lanarkshire Quality Approach and the staff spoke to us about a recent development the "Quality Improvement Board". The IPCU unit has been identified to pilot this project. They described the main headings within the project: promoting a culture of safety, care assurance and accreditation system (CAAS standards), infection protection and control, working in partnership with patients, improving quality and working in partnership with carers.

They have just commenced with early stages data collection, updated onto the Quality and Safety Information Board. The board allows a quick over view of all the areas the team are developing and progressing on. The board is in the ward corridor for staff, patients and visitors to view.

We look forwarding to hearing about the progression of this project and its impact on the improvement of patient care.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date of this report.

A copy of this report will be sent for information Healthcare Improvement Scotland.

SUZANNE MCGUINNESS
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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