Mental Welfare Commission for Scotland

Report on announced visit to: IPCU, Carseview Centre, 4 Tom Macdonald Avenue, Dundee DD2 1NH

Date of visit: 20 December 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The intensive psychiatric care unit (IPCU) at Carseview is a 10-bedded mixed-sex ward providing intensive treatment and interventions to patients who present an increased level of clinical risk and require a more individualised, intensive level of observation. This type of unit generally has a locked door and a higher ratio of staff to patients, due to the potential of increased acuity of mental health symptoms and distress of patients in an IPCU.

We last visited this on 19 February 2020; we made a recommendation regarding the physical environment, including the lack of storage for patients' personal belongings.

On the day of this visit we wanted to follow up on this and to speak to patients about their care and treatment.

Who we met with

We met with and reviewed the care and treatment of five patients, and spoke with one carer.

We also spoke with the service manager, senior nurses and the consultant psychiatrist for the ward.

Commission visitors

Alyson Paterson, Social Work Officer

Claire Lamza, Senior Manager

Gillian Gibson, Nursing Officer

What people told us and what we found

Care planning, treatment, support and participation

Comments from patients/carers

Most of the patients we met with during our visit spoke highly of the staff in the ward and they spoke positively of the care, treatment and support they had been receiving. We heard that staff were visible around the ward, were approachable and listened to patients. Staff were described as welcoming and those that we spoke with told us that they had good connections with staff. During our visit we saw staff communicating and interacting with patients on the ward.

Comments were mostly positive about the ward environment, with many describing feeling safe there. However we did hear that some patients found the environment restrictive; one patient described having to wait to be escorted out for a cigarette and found this difficult.

Patients were aware that they had a named nurse; some were aware that they had a care plan, some were not. Those that we spoke with felt involved in the creation their care plan and that their views were taken into account.

The carer we spoke to after our visit also spoke highly of the ward staff describing nursing staff as helpful and the ward as impressive. We heard that communication worked well as there was an identified point of contact where all queries could be directed to. This carer would have liked to have seen more activities on the ward and felt boredom was an issue. We also heard that the location of the IPCU can create difficulties, resulting in long journeys using public transport for some carers.

Care planning and treatment and support

We reviewed individual patient files that are stored electronically; we also looked at paper copies of care plans. NHS Tayside has produced a set of standards, 'Mental health nursing: standards for person centred planning'. To support the ongoing quality of care plans and documentation, audits are undertaken by the nursing team. We were told that patient file audits take place on a regular basis and areas of improvement where emerging themes and trends are reviewed, are then fed back to nursing staff. During this visit, we were pleased to find care plans that were detailed and person-centred, with information about specific interventions that met identified needs. We reviewed a number of different care plans and found that these were individualised and strengths-based. The care plans outlined needs, agreed goals and interventions and were regularly reviewed. We saw evidence of patient participation in some of our file reviews; we found that patients had identified their own coping strategies and patients have the opportunity to disagree with aspects of their care and treatment and this was then recorded and included in multidisciplinary meetings. We recognise that at times patients will be too unwell to engage in a discussion regarding their care plan, however we would like to see evidence of the attempts that have been made recorded in patient records.

We heard that the ward gathers patient feedback in a number of ways. The quality improvement team seeks to collate patient feedback on a routine basis. Previously ward based nursing staff did this, however there were some concerns regarding the objectivity of this, so the service has moved to a model whereby the feedback is facilitated by staff who do not work on the wards. This is an ongoing piece of improvement work. We were pleased to hear that the ward has weekly community meetings where patient feedback is on the agenda. Further feedback opportunities for patients are through the 'How are we doing' questionnaire devised by NHS Tayside to gather anonymous feedback from patients.

In the files we reviewed we saw comprehensive risk assessments which were person-centred and showed evidence of review. The assessments were detailed in terms of risk, however we did not find details of risk management. We would like to see the development of risk management plans which shows evidence of positive risk taking.

Recommendation 1:

Managers should support the development of risk management plans that encourage positive risk taking.

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/node/1203

Multidisciplinary input in the ward

We heard that there is input into the ward from a range of different disciplines, including consultant psychiatrists for the ward, an activities worker and a lead occupational therapist (OT). We were pleased to hear that OT provision in the ward has increased over the last 18 months. We heard about a range of activities which were offered by the activities co-ordinator including arts and crafts sessions and quizzes. We were made aware that the ward is awaiting on funding to become available to enable a snooker table to be purchased. Currently there is a staff nurse vacancy which has been difficult to fill.

We were concerned with the lack of availability of clinical psychology. We heard from patients and the clinical team that having psychology input into the ward would be hugely beneficial. The team told us that providing a model of care that offers psychological therapies, along with psychological formulations, would enhance clinical skills and knowledge, specifically in supporting patients who have a diagnosis of personality disorder.

During our visit we saw there were a number of patients in the ward who have complex needs, including some with a diagnosis of emotionally unstable personality disorder. Psychological therapy is considered to be a first line treatment for people with such a diagnosis and as such we feel this supports the need to have dedicated psychology input into IPCU.

Recommendation 2:

Managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

During our visit, we were made aware of patients who were ready for discharge however this was delayed for various reasons. In some cases it was due to issues such as accommodation; in others it was because there were no beds in an acute ward or in a low secure setting. In one case, the absence of a completed social work assessment had delayed the process of discharge planning. It is essential that discharge planning starts as early as possible during an admission to hospital to prevent patients being delayed in restrictive environments such as IPCU. We would like to see managers working closely with their colleagues in social work to ensure a discharge planning process is developed and implemented.

Use of mental health and incapacity legislation

On the day of our visit, the majority of patients were either detained under the Mental Health (Care & Treatment)(Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 ('CPSA'). The appropriate detention paperwork was filed appropriately and was accessible.

We reviewed a number of patients' files. Paperwork relating to the Mental Health Act was kept in a paper file and was accessible.

We reviewed forms for consent to treatment under the Mental Health Act (T2 and T3 forms). We found no issues or concerns regarding the required legal paperwork or the legislative authority for treatment forms.

When we were reviewing patient files we were looking for copies of advance statements. The term 'advance statement' refers to written statements, made under s274 and 276 of the Mental Health Act, and is written when a person has capacity to make a decision on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements, however on the day of our visit, we were not able to locate any advance statements. We understand that in an IPCU setting, many patients are acutely unwell which results in advance statements often being completed once individuals step down to a less restrictive environment. The Commission supports advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts made to engage in a discussion regarding advanced statements and the reason noted for any patient that does not have one.

One patient required restrictions to be placed upon them under sections 281-286 of the Mental Health Act. This provides a framework within which restriction can be put in place. The Commission would expect restrictions to be legally authorised and the need for specific restrictions regularly reviewed. On reviewing the file we were unable to locate a 'reasoned opinion'.

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

Rights and restrictions

For reasons of patient safety and other risk factors, the IPCU is a locked ward and patients are not freely able to leave the ward. The function of an IPCU ward is to provide care and treatment to patients who require intensive support, who may be acutely unwell and who may display significantly stressed or distressed behaviour. For an IPCU to function appropriately there needs to be the opportunity for patients to be able to move back to acute/specialist wards when either clinically ready to do so or when beds become available. IPCUs are small, highly staffed units which provide short periods of rapid assessment, intensive treatment and stabilisation for patients. We were advised during our visit that staff aim not to exceed 8 weeks admission time

On the day of our visit, there were individuals in the IPCU who were not detained under the Mental Health Act. The Commission considers that the admission of informal patients to an IPCU should only happen in exceptional circumstances and for the shortest time as is necessary. The patient should provide valid consent to such admissions.

On our last visit to the ward in 2020, we raised the issue of informal patients being admitted to IPCU. During this visit, we were made aware that there were informal patients on the ward. These patients did not require to be in IPCU and were awaiting transfer to a less restrictive environment. We spoke to one informal patient who told us that they wished to leave the ward. We were advised that this patient was receiving 'ward-based care' which meant they had no time out of the ward either escorted or unescorted. We were concerned that the patient was not clear, nor had they understood their rights an informal patient. The clinical team advised us that informal patients have their rights explained to them however we could find no evidence of this.

We were also made aware of individuals being inappropriately placed in IPCU due to a lack of beds in other, less restrictive, wards, including patients under the age of 18 and those with a primary diagnosis of learning disability. We remain concerned about the inappropriate placements of some individuals in the IPCU and the impact on patients who are not receiving the appropriate care in the least restrictive environment that will meet their needs.

At the feedback session for the visit, we discussed with the clinical team our concerns regarding the impact of informal patients being in a restrictive setting such as an IPCU. We recognise that there can be considerable difficulties in moving patients back to the other wards due to bed pressures, however these pressures need to be kept under review by managers due to the impact on patient care.

Recommendation 3:

Managers should develop a policy for admitting patients who do not require an IPCU bed and send updates to the Commission when this takes place.

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

The physical environment

A recommendation from our last visit related to the physical environment in IPCU requiring refurbishment as soon as possible. Additionally, we recommended that patients should be able to store their clothes and belongings appropriately. We were advised that the primary focus on the ward has been the on-going anti-ligature refurbishment work (replacement of bedroom and bathroom doors). We were pleased to see that all bedrooms now have a chest of drawers and patients have a storage box in a communal area where they can store belongings.

While we were pleased to see the ward has access to a garden and seating area, we were concerned to see evidence that smoking on hospital grounds is permitted and cigarette ends not been cleared away. Additionally we could smell cigarette smoke in the ward. This did not create a positive impression of the ward or outside area, which was not regularly maintained and appeared unkempt.

In the ward itself, we felt that there was pleasant atmosphere. We were pleased to see the 'nurses' station' used positively as a place for staff to interact with patients and the location of the exercise and sports equipment meant that patients could easily access this and staff could continue to observe.

Summary of recommendations

1. Managers should support the development of risk management plans which encourages positive risk taking.
2. Managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.
3. Managers should develop a policy for admitting patients who do not require an IPCU bed and send updates to the Commission when this takes place.

Good practice

We heard that in the last 12 months, the ward has implemented a framework to reduce violence and aggression in the ward entitled DASA (dynamic appraisal of situational aggression). This framework was developed to assist in short-term assessment of risk of imminent violence in mental health wards and follows a scoring model ranging from low to high. The tool predicts violence and aggression resulting in a safety plan being implemented when a patients scores high. The ward has identified times in the day when violence and aggression is more likely and has responded by putting in interventions to manage such situations, e.g., family visits or meetings which the patient can attend. This has resulted in a 25% reduction in incidents of violence and aggression. The Commission was impressed to hear about the positive impact the introduction of DASA has had on reducing violence and aggression. We would encourage its use to be shared more widely amongst the multi-disciplinary team.

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.

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 Commission 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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