Mental Welfare Commission for Scotland

Report on announced visit to: Ward 1, IPCU, St John's Hospital, Livingston EH54 6PP

Date of visit: 22 March 2022

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.

Ward 1, the intensive psychiatric care unit (IPCU) at St John's hospital is a 10-bedded, mixed-sex unit; it also has an enhanced care suite for any individual who may require additional support during their stay in hospital. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an enhanced 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. On the day of our visit there were no vacant beds.

We last visited this service on 20 February, 2020 and made recommendations about care plan audits, risk assessments and updating of the environment.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear what the impact had been for patients as a result of the pandemic.

Who we met with

We met with, and reviewed the care of five patients, four who we met with in person. There were no relatives that wished to speak with us regarding our visit.

We spoke with the clinical nurse manager, the senior charge nurse, and deputy charge nurse and other nursing staff. We also met with other members of the multi-disciplinary team, and advocacy on the day of the visit.

Commission visitors

Claire Lamza, senior manager

Anne Buchanan, nursing officer

Paula McCahon, ST6

What people told us and what we found

Care, treatment, support and participation

As was expected due to the remit of an IPCU, some of the individuals that we spoke with were experiencing significant mental ill health issues at the time of the visit. We heard that for some, they found being in hospital "unhelpful", and described the IPCU as "a bit like a prison". However, we also heard from others that staff were "brilliant", and individuals told us that they were "in a much better place", that "there was plenty to do", and that "if it wasn't for the staff here, I would be dead". Those that we spoke to were able to tell us about the activities that they were engaged in, and although there were restrictions relating to their care, they were aware of what these were. We were able to observe staff interacting and engaging with individuals in a calm and supportive manner, even when there were some patients that were distressed by their symptoms and expressing their views in emotive manner, in relation to their current situation.

We also had an opportunity to discuss with the ward-based staff about the recent development and use of the enhanced care suite. We heard some of the different approaches that have put in place to support patients who required their care and treatment to be delivered while in this area of the ward.

Care records

Documentation relating to care is mostly held on the electronic system used in NHS Lothian, TrakCare, although there were some documents that are still in paper format. We were easily able to locate all of the relevant information either on TrakCare, or in the paperwork.

We reviewed the care plans and found that these were detailed and person-centred. Those that we reviewed covered a breadth of different needs, including physical health, specifically relating to Covid-19 and medication, as well as care plans for time off the ward and activities that were undertaken with different professionals, such as the music therapist and the activity coordinators. We found the daily updates recorded by nursing staff to be informative in relation to the patient's ongoing mental state; although these provided details of when the patient met with staff, there was no formal record of one-to-one sessions, other than with psychology. We would suggest that nursing staff formally record when they meet with patients that they are the identified nurse for.

We were pleased to see that there is a regular peer review audit programme, completed by a senior charge nurse from a different clinical area. The evaluation of these reviews, undertaken every six months, provided clear evidence of the areas where the IPCU has effective systems in place for care plans, although the audit did highlight areas where improvements could be made. The most recent audit, completed a month before our visit, identified that the care plans were of a good standard, which we also found to be accurate. However, there was an action point about evidencing patient involvement in their care plans, which we would agree with. On the day of the visit, we discussed what opportunities could be put in place to evaluate the patient experience of being in an IPCU. We look forward to seeing how patient experience and engagement could be measured, audited and what the results of this are.

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 team (MDT)

The unit has a multidisciplinary team (MDT) of nursing staff, psychiatry, psychology, pharmacy, occupational therapy staff and activity coordinators; there is weekly input from services such as art and music therapy, and referrals to other services are made as and when required. At the time of our visit, the unit did not have a physiotherapist in post, although there were plans in place to recruit to this position.

The notes from the MDT meeting provided a clear outline of each discipline's involvement in the individual's care and treatment. We found the MDT's use of formulation, which had a strong psychological focus, promoted a shared understanding amongst the full clinical team, and helped establish a personalised approach to care; we could see the link between this and decisions taken relating to care and treatment. We noted this to be a proactive process and we were impressed with this skilfully implemented and useful approach in support the full MDT to meet the complex care needs of patients in the IPCU. When able to, we saw that patients were supported to participate in this meeting, or receive timely feedback from members of the MDT.

We also found comprehensive reviews completed after the weekly multi-disciplinary team meeting and that consequently, care plans were re-evaluated and updated.

Use of mental health and incapacity legislation

On the day of our visit, all patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we met with during our visit were aware of, and understood their status under the Mental Health Act. All documentation and correspondence pertaining to the MHA was in place and up to date.

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. We found that where required, certificates authorising treatment (T3) under the Mental Health Act were in place, and corresponded to the medication that had been prescribed. We found that all T3s had been completed by the responsible medical officer, were readily accessible and up to date.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found this noted in the patient's record.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We note that due to the patient's mental state at the time of being in an IPCU, it may be difficult to complete an advance statement, however, we would suggest that it is

possible to begin discussions with an individual about developing an advance statement; we would like to see how the IPCU can develop this when we next visit.

Rights and restrictions

Ward 1 has a locked door, and this is required due to the level of risk identified in the patient group. Those that we spoke to on the day of the visit were aware of the restrictions required in an IPCU.

We found the risk assessment documentation in the electronic records to be detailed, and it covered historical and current aspects of risk. The assessment linked to the team formulation and provided a comprehensive overview of possible triggers, stressors and protective factors that supported the principles of trauma-informed practice for each individual. We noted that the assessments were updated regularly.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. For those patients in Ward 1 where specified person restrictions were in place, we found reasoned opinions in the patient's record and they were aware of the associated restriction; they were also aware of their right of appeal. We were also pleased to see that the use of specified persons forms part of the regular audit cycle completed for the ward.

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

The audit process also reviews the use of the enhanced care suite (ECU), and while there were no patients who needed this level of care on the day of our visit, we were able to review information based on the frequency, and reasons for use, when the ECU had been required. It was helpful to note that this level of restriction lasted for short periods of time, and that there was a formal review process in place for any patient in the ECU.

At the time of our visit, advocacy was present in the ward and we were able to hear about their input during and post-Covid-19. The service has now fully returned to face-to-face contact, and patients can easily request input and support from this service. Those patients that we spoke with were all able to advise us of their right of appeal for their detention under the Mental Health Act, and in relation to any restrictions place upon them.

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 heard from those that we spoke with about a diverse range of activities that were available on the ward. There was an activity calendar displayed that set out what was scheduled to take place in the unit, supported by the OT staff and activity coordinators.

Activities and meaningful occupation included mindfulness and psychological therapies, where a personalised “my calm card” provided identifiable ways for each patient to manage their agitation and distress. Each patient was offered the option to develop one of these, and a copy was also available in the patient’s record. We also found that activities that each patient engaged in was regularly recorded in the ongoing care record.

We were aware that patients were involved in current affairs groups, baking groups, social events such as pool competitions and games sessions, access to the on-ward gym, weekly music sessions, as well as activities such as painting, papier-mâché and clay modelling with the art therapist. For some individuals, they had access to time off the ward; for others, they were escorted by ward based staff for this.

The physical environment

Following on from our previous visit, and recommendation about the environment, we were pleased to see that improvements had been. We noted the upgrade to the flooring, and to the furniture, which freshens and modernises the ward. Although Ward 1 is on the lower ground floor, the ward is bright and well-lit.

Patients have their own rooms, which are en-suite, and with the reduced number of beds, the ward felt more spacious, where patients to move around, and find quiet, alternative spaces without having to go to their bedrooms.

The outdoor space continues to be well used for patient activities; there are some seating areas and large planting beds to encourage outdoor activity, and another space for patients to use away from the main ward area. We heard about plans to turn an under-used space into a family visiting area, and note that this will be a welcome addition for patients, who may have young children that wish to visit. Currently Ward 1 does not have an appropriately safe space to accommodate this. We look forward to seeing this development on our next visit.

Summary of recommendations

No recommendations were made for this visit.

Good practice

We found the approach used in Ward 1, where team formulation, based in a psychological framework that incorporates trauma-informed practice, provided a strong and inclusive approach in the review of patient care. We were impressed to see, and had the opportunity to participate in, how this is used routinely to enhance reflection, and positive relationships amongst members of the clinical team.

Service response to recommendations

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

Claire Lamza
Executive director (nursing)

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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