Mental Welfare Commission for Scotland

Report on unannounced visit to: IPCU Ward 8, Woodland View Hospital, Kilwinning Road, Irvine KA12 8SS

Date of visit: 2 November 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 8 is an intensive psychiatric care unit (IPCU), situated in Woodland View Hospital; it is located on the Ayrshire central Hospital site in Irvine. The ward is an eight bedded purpose built facility for patients aged 18-65, that provides intensive treatment and interventions for individuals who present with 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.

We last visited this service on the 10 May 2021, and made no recommendations on that visit.

On the day of this unannounced visit to the service, we wanted to meet with patients and review the care and treatment provided in the IPCU.

Who we met with

We met with four patients on the ward, and reviewed the care and treatment of all the patients interviewed. As this was an unannounced visit, we were unable to meet with any carers or relatives on the day of our visit.

We spoke with the senior charge nurse and other members of the nursing team. We also met with the service manager and the general manager for in-patient services at our end of visit meeting.

Commission visitors

Mary Leroy, nursing officer
Mike Diamond, social work officer

What people told us and what we found

Care treatment support and participation

Most of the patients we spoke to during the visit told us that they felt they were receiving good care and treatment in the unit. Some patients were unable to give details on their stay due to the acuity of their symptoms. For those patients that were able to, they described the routine on the ward, and support they had received from the clinical team. They told us that the staff were approachable and supportive. They commented that they met with a member of the nursing team to prepare for the multidisciplinary team meeting (MDT).

We were told about the 'nurse-led model' of care in the ward. This model has had a positive impact on the patient experience and outcomes. We spoke to staff throughout the day and we were able to see that the staff team knew the patients extremely well. There was a sense of commitment and experience in the staff group that came through clearly when speaking with the staff.

We saw care plans that were detailed, person-centred and addressed a wide range of needs arising from the complex presentations of this patient group. In the care plans, we found good evidence of patient involvement.

Physical health screening was documented, assessments were ongoing and care plans relating to the individual's physical health were detailed.

Nursing care plan evaluations and reviews were regularly updated; in the individual files we reviewed, we saw that the reviews were thoughtful, meaningful, and detailed the progress and changes in patient care.

The patients on the ward have their care and progress managed using the Positive Support (PBS) plans and for some the Care Programme Approach (CPA), risk assessment formed an essential component of all care plans.

On reviewing the individual's files we saw evidence of detailed assessment, supported by risk assessment and risk management plans. Risk management plans were reviewed regularly throughout the patient's journey. We noted that the risk assessments were up-to-date, dynamic and regularly reviewed.

Chronological notes evidenced regular one-to-one discussions between the patient and nursing staff. It was clear that the patient's views on their care and treatment were sought and the patients were aware of their legal status. We also noted evidence of family involvement, either in discussions regarding care and treatment, or in general contact with family/ carers.

Multidisciplinary team (MDT)

The ward provides a multidisciplinary team (MDT) approach to care and treatment. We did note that those who attended those meetings were primarily the consultant psychiatrist and the nursing staff.

The senior charge nurse (SCN) informed us that the unit has access to psychology, occupational therapy, physiotherapy and dietetics on a referral basis. We were told that the

respective allied health professionals were responsive when a referral is submitted. Social work and advocacy are also accessible.

Multidisciplinary team medical cover

The team discussed on going challenges relating to the organisation of the weekly MDT meetings; all patients in the IPCU have input from the consultant psychiatrists in their own locality. Due to service demands the consultant psychiatrist initially attends the MDT meetings in their respective wards, and are therefore often unable to give a specific time for the MDT meeting in the IPCU. This matter has been raised on previous visits to the service. At the end of day meeting with senior managers we were informed the service are seeking a solution and will notify the Mental Welfare Commission with this information.

The MDT meeting records were well documented, with a record of who had attended, and contained a concise summary, with clearly recorded outcomes and actions.

We discussed with the clinical team the 'patient flow' through the service. We enquired about patients who were fit for discharge, but where discharge was delayed. There were some patients who have been in the IPCU for a considerable length of time. For some the length of stay was due to the nature of their illness, and the complexity of their care needs; for others it is the challenge of finding suitable community placements to meet their complex needs.

At our end of day meeting with senior staff and the management team, we discussed ongoing concerns in relation to patients remaining in hospital when they are considered fit for discharge. This position remains a source of frustration for patients, relatives and the clinical team. We recognise this is a nationwide concern, and the clinical team discussed ongoing issues in finding appropriate specialist services that the patients may require. There are also challenges in securing suitable tenancies and packages of care in the community, to support the individual needs.

For some who are ready for discharge, referring the patient back to the respective sector ward could be challenging, as the acute ward may be at capacity with the admission of new patients.

Both the MDT meeting record and the chronological notes have documented that these matters were being actively addressed by the clinical team involved. We appreciate that this is under regular review and we will be seeking updates from the management team in relation to progress.

Recommendation 1:
Managers should ensure that as well as regularly auditing delayed discharges processes, that work should continue alongside partners to expedite discharge.

Use of mental health and incapacity legislation

On the day of our visit all patients were subject to the Mental Health (Care and Treatment (Scotland) Act 2003 (the Mental Health Act). Patient records contained the appropriate legal paperwork and all consent to treatment certificates (T2) and certificates authorising treatment (T3) were current and appropriate.

For those patients in the ward who were under sections 281 to 286 of the Mental Health Act, specified persons guidance provides a framework in 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. We found that for those patients who were specified, there was evidence of a reasoned opinion having been carried out appropriately.

All paperwork relating to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) was available, including copies of welfare 'proxies' guardianship orders. For one patient, a copy of the powers, was held on file in the chronological notes, but not pinned in respective alert area on the electronic file. This issue was addressed and amended by the senior charge nurse on the day of our visit.

Where a patient was assessed to lack capacity in decisions relating to medical treatment, a certificate completed under section 47 of the AWI act must be completed by a doctor. We were able to access all section 47 certificates and their accompanying treatment plans.

Rights and restrictions

The IPCU operates a locked door policy in line with their remit of an intensive treatment area. On the day of our visit there were two patients requiring a higher level of staff support with continuous intervention. There is recognition from the senior leadership team that continuous intervention is at times necessary in order to support patients during the acute phases of distress and illness, although it can be considered a restrictive practice. In the IPCU there are a number of restrictive practices commensurate with the level of risk. There are requirements to ensure safety to patients and staff is not compromised and procedures in place to reduce potential risk to safety and security.

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 discussed the activities that are available in the ward and that some recreational and social activity on the ward were being offered by nurses. We were told that there were attempts to engage patients in a range of activities. Due to the nature of the patients' needs most activities are on a one-to-one basis.

There is a small gym in the ward which is well used by patients, which is accessible following an initial induction session on how to use the equipment safely; the gym can be used flexibly with staff supporting and supervising patients if necessary.

There is also a weekly session available at the Beehive Unit. This input is delivered by the occupational therapy department, and provides recreational and therapeutic activities.

From the patient records it was difficult to identify recreational activities being offered to patients. Some patients commented that there was limited opportunity for structured activities and we found this to be the case with the provision of activities in the IPCU. We have been told on previous visits about the role and input from the occupational therapist (OT), who

has been able to provide group work and structured activities, and that these were appreciated by the patient group.

As with the previous report we were informed that there is no occupational therapist available, for dedicated input. We heard that OT input has been limited due to recruitment issues, but that efforts to fill this post are ongoing.

The physical environment

The physical environment in the ward is of a high standard. It is modern, bright, clean and spacious. All bedrooms are en-suite and are purpose built; patients are able to come and go from their rooms as they wish.

The large sitting room is comfortable and nicely furnished, offering immediate access to the secure courtyard. There are also smaller sitting rooms that provide patients with a choice of where to sit. This space is of particular value for patients who may prefer a smaller, and quieter space.

The ward has its own courtyard and garden which is landscaped with plants and shrubs, and this outdoor space is appreciated and well used by patients.

Any other comments

On the day of our visit, the clinical team told us, that the ward had been identified as a pilot team for the Scottish Patient Safety programme. This is part of a national collaborative to ensure “everyone in adult mental health in-patient wards experiences high quality and person-centred care every time”. This will be achieved by supporting hospital teams to improve observation practice and reduce harm from restraint and seclusion practices

For the IPCU this improvement and training was focussing on human rights and trauma-informed care, and the reduction of restraint and seclusion.

We were able to access information from the service dashboard that focused on many aspects of patient care. For the period of a year, we were able to see the rates of physical aggression/ self-harm, rate of restraints in the service. We were able to quickly see that at certain times where there was a significant reduction in the use of restraint, and when the staff team were utilising a positive approach to managing behaviour that challenges, specifically through redirection and de-escalating techniques.

We look forward to hearing, on our next visit to the service, about this ongoing development/initiative and its impact on improving patient care.

Summary of recommendations

Recommendation 1:
Managers should ensure that as well as regularly auditing delayed discharges processes, that work should continue alongside partners to expedite discharge.

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 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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