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: 28 June 2023

Where we visited

The Intensive Psychiatric Care Unit (IPCU) is a mixed-sex, six-bedded facility in University Hospital Wishaw General. IPCUs provide intensive treatment and interventions to patients who present with an increased level of clinical risk and require an increased level of observation. They generally have a higher ratio of staff to patients, and a locked door. It would be expected that the staff working in an IPCU have skills and experiences in caring for acutely ill and often distressed patients.

We last visited this service on 30 August 2021 and made a recommendation about consideration of the window coverings in the rooms to give some privacy. The response we received from the service was that managers would explore alternative options for the window coverings taking into consideration patient safety and health and safety requirements.

On the day of this visit, we wanted to follow up on the previous recommendation, to hear from patients, staff and relatives/carers, as well as look at the care and treatment being provided on the ward.

Who we met with

We reviewed the care notes of five patients. None of the patients on the ward wished to meet with us in person. No relatives had expressed an interest in meeting with us or having any contact with the visiting team.

We spoke with the service manager, the senior charge nurse, the consultant psychiatrist, and the consultant psychologist.

Commission visitors

Anne Craig, social work officer

Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support and participation

During our visit, we observed staff actively engage with the patients, and the atmosphere in the ward was supportive and positive. Interactions between staff and patients were calm, although directive. Staff that we spoke with knew the patient group extremely well.

There were also supportive interactions between staff, and it was evident that there was a team commitment in relation to the care being delivered. Working as a team in this way highlighted the effective leadership in the ward, and we fed this back to the management team at the end of the visit.

We noted that staffing levels were good in IPCU. We heard from the senior staff team that they had initial discussions about seeking Accreditation for Inpatient Mental Health Services (AIMS) also known as Quality Networks and Accreditation, from the Royal College of Psychiatrists. These discussions are in the early stages and there was a clear will and commitment to seek accreditation in the future. We look forward to hearing about progress on our next visit.

Care plans and nursing notes

At our last visit, Morse, a new electronic recording system was being introduced. For this visit, we found that information on a patient's care and treatment was held in three ways; on Morse, and two paper files. One paper file contained the detention paperwork for the patient and the other held information for quick reference such as records of the GP, community psychiatric nurse etc. All the information contained in the two paper files was also on Morse, and we found this easy to use. IPads are available for staff to use whilst recording blood pressures and for use with Hospital ePrescribing and Medicines Administration (HEPMA).

We could see from the records that care plans were detailed and person-centred. They focused on the physical and mental health of the patients and had clear links to multidisciplinary team (MDT) decision making. There was a focus on the physical health of the patients on the ward and several patients had significant physical health conditions, some of which were noted to be life threatening.

There was evidence of regular and detailed reviews of the care plans. We also found detailed information contained in patients' one-to-one discussions with their named nurse. The care plans provided a good account of the patient's journey and recovery.

Although we were unable to speak with any of the patients or relatives, we noted the comments in the case notes. One comment from a family was that they "were happy with the care and treatment of their loved one" and there had been a "definite improvement" in them.

Risk assessments were robust and detailed; they used a traffic light system, and we found it easy to see where the risks were identified, with subsequent further explanation at the end of the section.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. It was clear from the very detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and provide an update on their views. This also included the patient, and their families should they have wished to attend. MDT meetings are all now held on the ward and the notes showed patient involvement and their satisfaction with their care.

Use of mental health and incapacity legislation

On the day of our visit, all five patients on the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). There were recordings in the care notes of discussions with the patients about their detained status.

There were three patients on enhanced observations during our visit. The impact on staffing was noticeable but was being managed in relation to the needs of the patients at that time by two-to-one and one-to-one support.

All documentation relating to the Mental Health Act, including certificates around capacity to consent to treatment, was in place in the paper files and was up to date. There were no patients subject to Adults with Incapacity (Scotland) Act 2000.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up to date. We found good rationalisation for medication administration and titration.

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 copies of this in the patient's file.

Rights and restrictions

IPCU University Hospital Wishaw General operated a locked door policy, commensurate with the level of risk identified with the patient group.

Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. Sections 281 to 286 of the Mental Health Act provide 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 were introduced, it is important that the principle of least restriction is applied. One patient was a specified person, and all paperwork was on file and recorded appropriately.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 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 did not see any advance statements in any of the patient files.

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 are aware that during the pandemic, restrictions put in place had meant that various activities out with the unit had to be put on hold. There was no dedicated activity nurse in the ward, but we saw that activities were available to patients, facilitated by the ward staff and the occupational therapy team. Where deemed clinically appropriate, patients can take an accompanied walk with members of the MDT and for some patients this was part of their therapeutic interventions. Staff were keen to ensure that patients' needs in this area are met.

The physical environment

The environment was immaculate, and we were able to see where efforts had been made to soften corridors and the public rooms with artwork and prints on the walls.

The layout of the ward consists of six single en-suite rooms with showers. There was a separate bathroom area that could accommodate patients who had physical disabilities requiring more specialist equipment. There was a communal lounge area with a separate lounge area for female patients, if required. The dining area was large, bright, and welcoming.

Due to ongoing building work in accident & emergency, which is directly above the ward, the outdoor area is restricted at present due to scaffolding on the outside of the building. This was temporary and we look forward to seeing the whole garden area on our next visit. We consider that it is important for patients to have access to outdoor safe space.

On a previous visit we made a recommendation about window coverings. This had not been progressed, however, we were told that as an alternative to new window coverings where opaque film is currently providing privacy, there was a plan to replace windows in all areas in the hospital, although no timescale is available for this at present. We look forward to hearing how this has progressed when we next visit.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk