Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 8, Intensive Psychiatric Unit (IPCU) Woodland View, Kilwinning Road, Irvine, KA12 8RR

Date of visit: 11 December 2023

Where we visited

Ward 8 is the Intensive Psychiatric Care Unit (IPCU), an eight-bedded purpose build facility in Woodland View Hospital; there were seven individuals in the ward on the day of our visit. 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 policy. 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 in November 2022 and made recommendations in relation to auditing delayed discharge processes and continuing to work alongside partners to expedite discharges. We received a response from the service, with appropriate actions relating to the recommendations.

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

As at the time of our last visit to the service we also wanted to find out if there had been progress made towards providing a consistent consultant psychiatrist presence in the IPCU.

Who we met with

We met with, and reviewed the care of all seven patients, three who we met with in person and four who we reviewed the care notes only.

We spoke with the service manager, the senior charge nurse, two staff nurses, and the consultant psychiatrists.

Commission visitors

Gemma Maguire, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

Most of the patients in the ward on the day of our visit had very complex clinical needs. Some patients were so acutely unwell that it was not possible to have any conversation with them about their care and treatment.

The patients we did speak to generally reported that there was good support from staff in the ward and said the nurses were helpful and approachable. Some reported feeling uninvolved in their care and treatment and that they did not agree with being detained in the ward. They told us that they were aware of their right to appeal their detention; on reviewing their notes we saw that their views and wishes were considered in their care plans and in the review meetings. Although they advised us that they were unaware of advocacy, we saw this was well promoted in the ward, and it was recorded in their notes that this had been offered. We discussed this with staff and suggested it may be worth revisiting advocacy contact at each MDT review. Advocacy services are available from the three health and social care partnerships within Ayrshire. During our time on the ward, we saw staff interacting and communicating with patients in a positive and supportive manner. Staff that we spoke with knew the patient group well.

It was good to note that patients we met with, although unhappy at being on the ward, reported the staff were ''alright''.

Ward 8 benefits from good leadership and has developed clear processes which enable a consistent and predictable nursing process; this is especially important in a potentially volatile environment. We were struck by the different levels of needs and requirements of care in the ward. The mix of patients, with a variety of extremely complex needs makes this a challenging place to nurse, but we found a calm containing environment that aimed to support recovery.

When we last visited the service, we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. On this occasion, we again found detailed person-centred care plans that evidenced patient involvement and were pleased to find patient discussions informed some of the content and review of these plans. It was clearly documented where the person disagreed with their plan of care or was unable to engage with the care planning process. We also found a good deal of information contained in patients' one-to-one discussions with their named nurse. We were able to locate regular weekly reviews of care plans that targeted nursing intervention and individuals' progress.

Physical health care needs were being addressed and followed up appropriately and we saw liaison with professionals from other specialisms where this was required, for example learning disability services and old age psychiatry.

Multidisciplinary team (MDT)

We saw in the electronic notes evidence of regular, weekly multidisciplinary team meetings (MDT) with inclusion of relevant professionals. The multidisciplinary team (MDT) consisted of a core team involving nursing, psychiatry, pharmacy, with other disciplines such as psychology, occupational therapy, dietetics, physiotherapy, social work, speech and language

therapy, and forensic psychology available and attending as required. The MDT meeting records were well-documented, and recorded who attended each meeting, as well as containing a concise summary, with clearly recorded outcomes and actions.

We would have liked to have seen more structured input from psychology services that would have supported psychological formulation and reflective practice in the ward, as well as offering psychological interventions and supervision in the team.

We noted that occupational therapist (OT) services were available on a referral basis only. We discussed on the day the value of OT input in providing a functional assessment, and in supporting additional structured activity and individual sessions.

Given the complexity of the patient group, we felt there was a need to review the input from psychology and occupational therapy services.

Recommendation 1:
Managers should review the input from psychology to the wards and verify that it is sufficient to meet patients' needs.

During our previous visits, we had heard from staff about the difficulties that were caused from having consultants from the patient's own area visiting to cover their care. We were pleased to hear that since the recruitment of a permanent consultant psychiatrist to Ward 8, the situation is much improved. We heard there is now better structure and consistency of approach in the MDT meetings, and staff reported how having the responsible medical officer (RMO) based on the ward has improved communication. We were impressed by the consultant's enthusiasm and motivation to ensure optimum care and consider how services could be improved.

The clinical team discussed ongoing issues with finding appropriate services/placements and beds in other areas when individuals no longer required the level of care Ward 8 offers. Work has been undertaken to improve pathways into Ward 8; the staff group are now working to improve transitions out of the ward. We look forward to hearing about this work on our next visit.

Use of mental health and incapacity legislation

On the day of our visit, all of the patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act). The patients we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act or the Criminal Procedure Act.

All documentation relating to the Mental Health Act, the Criminal Procedure Act and the Adults with Incapacity (Scotland) 2000 Act (the AWI Act), including certificates around capacity to consent to treatment were in place and were up-to-date. We did not find copies of welfare guardianship orders under the AWI Act available in the files of those individuals who were subject to this legislation. We raised this with the service on the day and staff will request this documentation from welfare proxy.

The Commission is working in partnership with NHS Education for Scotland to develop learning resources for the workforce to support and promote people's rights in the application of the AWI Act. Learning resources can be accessed here:
Adults with Incapacity Act | Mental Welfare Commission for Scotland (mwcscot.org.uk).

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, but in one case this did not correspond to the as required medication being prescribed. This was raised on the day and the appropriate remedy was actioned by the RMO. We found that all T3s had been completed by the RMO to record non-consent; they were available to view 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 copies of this in the patient's file.

For patients who had covert medication in place, all appropriate documentation was in order. The Commission has produced good practice guidance on the use of covert medication at: https://www.mwcscot.org.uk/node/492

Rights and restrictions

Ward 8 continues to operate a locked door, commensurate with the level of risk identified with the patient group.

There were six of the seven patients in the ward who were subject to specified person regulations. 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 these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

From the records we reviewed, we found the restrictions had been legally authorised. It was difficult to locate the recording of the reasoned opinion for these restrictions, although we were pleased to hear about the ongoing work to develop a standard operating procedure for the use of sections 281 to 286 which NHS Ayrshire and Arran is developing for RMOs to use. It is expected this will ensure reasoned opinions are easily accessible in an individual's notes. We look forward to seeing progress in this area on our next visit.

We were informed that all individuals subject to restrictions were informed verbally and given written information about the review and appeal process.

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

Two individuals were subject to enhanced interventions on the day of our visit. One was being nursed in seclusion due to the level of distress and agitation he was displaying. We found

appropriate documentation, recordings and reviews of the measures that were in place, and that followed the agreed Ayrshire and Arran health board policy.

We were concerned to hear that delayed discharges and inappropriate placement could, at times, impact on individuals' access to family visits. Due to the risks and security needs of the environment, visitors were unable to access all areas in Ward 8; we felt this was commensurate with the risks described. However, it did impact on the ability for family visits to take place in some instances. This occurred when an individual was unable to move to an area visitors could access due to their own agitation or distress. The individuals in question had particular needs in terms of placement and there were ongoing challenges in identifying a more suitable environment. We appreciate that this is under regular review, and we will be seeking updates from the management team in relation to progress, for those patients whose discharge is delayed and those whose visits are limited in this way.

At our last visit we discussed ongoing concerns in relation to patients remaining in hospital when they are considered fit for discharge with senior management. This position continues and remains a source of frustration for patients, relatives and the clinical team. Both the MDT meeting record and the chronological notes have documented that these matters were being actively addressed by the clinical team involved and with health and social care partnerships. We recognise this is national concern.

The service also highlighted the ways in which they are addressing this issue. All patients whose discharge was delayed were under regular review through multidisciplinary team meetings and weekly summary reports that were submitted to the head of service. There were also links with discharge liaison groups, to review all delays for patients along with regular meetings with bed managers, with social work representatives and teams from the individual's home area. We appreciate that this is under regular review, and we will continue to seek updates from the management team in relation to progress.

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

The Commission recognises the importance of therapeutic and recreational activities, and we were pleased to hear from patients and staff that this was something they valued, either as one-to-ones, or in small groups.

Patients had access to a ward-based gym, and we heard this is well used. Staff support more informal activities and we saw activities and outings planned in individuals' care plans. There was also a therapet who had weekly visits to the ward to visit one individual who could take the dog for walks.

However, we heard previously there had been a dedicated member of the team who could invest their time into activities with patients, and this had been seen as a very beneficial addition to the team, but there was no longer someone in this role. Activities were being

undertaken by ward-based nursing staff and, with competing demands, they were unable to increase this provision to support patients with a bespoke activity timetable.

Furthermore, without a dedicated occupational therapist to engage with patients, both in relation to therapeutic individualised engagements and group work, there was a sense that patients were likely to be missing opportunities that could improve their admission to hospital or help maintain skills to reduce the risk of further institutionalisation. We heard there is access to specialist OT assessment when needed, but staff felt having dedicated OT input could help identify further OT interventions that the team might not consider.

We were disappointed with the lack of progress in having a detailed, imaginative programme of activities provided by a co-ordinator for this ward and designated OT input as this was discussed at our two previous visits.

Recommendation 2:
Managers should review activity and occupational therapy provision for Ward 8 to ensure patients are provided with regular therapeutic and recreational activities.

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 open plan dining room/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 two outdoor spaces, one of which is landscaped with plants and shrubs. There is also a tarmacked sports area. These outdoor spaces are appreciated and well-used by individuals. Staff let us know that having more than one sitting and garden area was particularly helpful when there were individuals who wanted to be separate from others.

Summary of recommendations

Recommendation 1:
Managers should review the input from psychology to the wards and verify that it is sufficient to meet patient needs.

Recommendation 2:
Managers should review activity and occupational therapy provision for Ward 8 to ensure patients are provided with regular therapeutic and recreational activities.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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