Mental Welfare Commission for Scotland

Report on unannounced visit to: IPCU, University Hospital Wishaw, 50 Netherton Street, Wishaw, ML2 0DP

Date of visit: 25 February 2020

Where we visited

The intensive psychiatric care unit (IPCU) in Wishaw General Hospital is a six-bed purpose-built unit. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased 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.

The ward takes both men and women, and provides a separate sitting room for women. Bedrooms are single rooms with each room having its own en-suite wetroom. The multidisciplinary input to the unit is from nursing, medical, and occupational therapy staff. All other allied health professional input can be accessed via referral.

We last visited the unit on 6 November 2018, at that time we made recommendations around care plan reviews and multidisciplinary notes. At the time of our recent visit there were two male and two female patients in the ward all of whom were detained under mental health legislation.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

Who we met with

We met with and reviewed the care and treatment of all four patients

Commission visitors

Margo Fyfe, Nursing Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

When we last visited we found care plans to be person-centred and recovery-focused. The care plans were easy to navigate and interventions were clearly stated. We noted that reviews happened approximately every three days. However, although there had been some improvement in the detail of review information, there was inconsistency in records. As a result, it was not always easy to follow the patient's progress towards the care plan goal. We are aware that audits had been carried out after our last visit which had helped ensure a more consistent approach to care plan reviews. However, we are also aware there have been staff changes and we would once again recommend that an audit of care plan reviews is carried out to ensure consistent, meaningful entries are made when they have taken place. On speaking with individuals, it was clear they were aware of their care plans and felt included in discussions around their care and treatment.

The nurses' continuation notes clearly documented individuals' mental state presentation during each shift and included a note of how the person had spent their day. We found one-to- one sessions detailed the person's wellbeing, their understanding of their illness, and stage of recovery. It remains clear from the notes that families and carers are communicated with regularly and given the opportunity to input to their relative's care.

Multidisciplinary team (MDT) meeting notes continue to be informative. We found they included patients' and carers' attendance (where this was wanted by the individual) along with the full list of attendees. It was good to note the forward plans on each MDT meeting minute. Where appropriate, there were clear transfer plans in these notes. During our last visit we noted that MDT notes were not recorded in the MDT field on the electronic record system but were held within the continuation notes. We recommend that this was changed to use the correct field for ease of reference of all care staff. We were pleased to see this had happened and that all staff used the correct record field on the electronic record system, MIDIS.

Although records are held on the electronic record system, MIDIS, there is a separate paper file for all legal documentation and a back-up 'paperlite' file for use when the electronic system is not available.

Recommendation 1:

Managers should audit care plan reviews to ensure review entries are consistent and meaningful.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

We found legal documentation for each individual held in a paper file within the duty room. This can be easily accessed by all staff. Consent to treatment forms were in these folders. We noted that one consent to treatment form needed to be updated to cover all current psychotropic medication prescribed. We brought this to the attention of the senior charge nurse who will ensure the consultant psychiatrist for the patient is made aware of the issue and can arrange for this to be reviewed. We suggested that it may be helpful to check the validity of consent to treatment documentation once a month at the MDT meetings. We were informed that the electronic prescription system Hospital Electronic Prescribing and Medicines Administration (HEPMA) is about to come into use in the unit and we look forward to seeing how this has bedded in at future visits.

Rights and restrictions

This unit is a locked environment. There is a policy in place on the use of locked doors, and all individuals and their families have this explained to them at the time of admission. Individuals are also given an informative in-patient pack that nurses will go over with them when appropriate.

There is also a policy in place detailing the restrictions on mobile telephones within the unit. When we previously visited we suggested that it may be helpful for patients to have a copy of this, once they have settled in the unit, which nurses could go through with them to ensure clarity for all patients around this particular restriction. We were informed that the pack given to patients on admission to the unit is currently under review. The new packs will give information on restricted items with clear explanations for the restrictions. We look forward to seeing the admission pack in future visits.

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

We were told that the unit has a low use of restraint and that all use of restraint is detailed on Datix forms and debriefing with patients and staff occurs after each episode of restraint.

We were informed that there is no seclusion room in use and that patients are nursed on higher levels of observation in their own room only when they are distressed and require privacy to respect their dignity. The Commission has recently produced guidance on use of seclusion. We recommend that wards, which impose restrictions to patients' freedom of movement, develop a policy on use of seclusion with reference to our guidance.

This can be found at: https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf

Recommendation 2:

Managers should ensure a seclusion policy is put in place to reflect any restrictions to patient's freedom of movement.

Activity and occupation

We heard from staff and patients that activities are mainly provided on a one to one basis due to the acuteness of illness individuals are experiencing when in the unit. Nursing and occupational therapy staff provide activities that range from helping patients understand their illness and how to cope better with their symptoms, to recreational activity such as cooking, visiting the hospital café, and exercising. As patients progress, staff focus on getting them out of the unit for short periods each day in preparation for returning to open wards.

Occupational therapy staff also engage in individual assessments, where this is appropriate, for patients moving on from the unit.

The physical environment

The unit is situated on the basement level of a busy district general hospital. As well as the individual en-suite bedrooms, the unit has a communal sitting room, a women-only sitting room, a dining room, and an activity/relaxation room. There is access to an enclosed garden space. There is also a family room situated outside the ward entrance.

Corridor light bulbs were being replaced during the visit. There were no outstanding repairs in evidence and the unit was clean and bright.

Any other comments

When we visited the unit in 2018 we discussed the input of psychology and pharmacy to the unit and we were pleased to hear that dedicated psychology input had been agreed. However, on this visit we were informed that the situation had not changed and that there remains no dedicated psychology for the unit. We heard about staff training around therapeutic interventions but did not hear about structured supervision being available from psychology to allow the staff to use their training. We are keen to hear how this issue is being resolved.

Unfortunately, there has also been no change to the pharmacy input to date. We understand that pharmacy staff are responsive to requests for assistance, however they do not attend the unit regularly or carry out medication audits on a regular basis. We are aware this has changed for the open wards on site and are keen to hear how this issue may be resolved for the unit as this area is likely to have patients who require high dose medication monitoring.

Recommendation 3:

Managers should review the issues of psychology and pharmacy input to the unit as best practice with a view to ensuring patients have access to the services when they are most unwell.

Summary of recommendations

1. Managers should audit care plan reviews to ensure review entries are consistent and meaningful.

2. Managers should ensure a seclusion policy is put on place to reflect any restrictions to patient's freedom of movement.

3. Managers should review the issues of psychology and pharmacy input to the unit as best practice with a view to ensuring patients have access to the services when they are most unwell.

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.

MIKE DIAMOND
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 MWC 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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