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: 8 October 2024

Where we visited

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

On the day of our visit, there were six people in the ward. One person was on the waiting list for admission.

We last visited this service in June 2023 on an announced visit and made no recommendations.

The service is in the process of seeking accreditation from the Royal College of Psychiatrists Quality Accreditation Network. We were told that the service is also contributing to the newly developed Scottish IPCU network. This is a multi-disciplinary professional group which has a focus on learning and good practice.

Who we met with

We met with, and reviewed the care of six people, three of whom we met in person and three who we reviewed the care notes of. We also met with the family members of two people.

We spoke with the service manager, the senior charge nurse, the lead nurse, and consultant psychiatrist prior to, and during, our visit.

Commission visitors

Margo Fyfe, senior manager

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

The people and family members we spoke with were very positive about the IPCU staff.

One person said that they struggled with the size of the ward but liked to have their own room and shower. We heard that they enjoyed the group activities and going out; they also liked the food in the ward. They told us that they had no concerns about their care and treatment.

Another person said that they liked the other people and the staff in the ward. We heard that they had been out to a gardening group that morning and were going out with a walking group the next day. They had some questions about their future and said that they would be able to speak to the nursing team about them.

One family told us that the staff "couldn't do enough for their relative" and would go "above and beyond" to meet their needs. They told us that they were able to visit with their relative at the best time of day for the person, that they were supported to maintain their relationship and had support in the ward. They spoke about the extra things the nursing team did to help their relative and the efforts the doctor had made to help.

One family member told us that she was glad that her relative was "being looked after" in the IPCU and went on to say that they had "a lot of faith" in the doctor and were pleased that the doctor was reducing medication to get a clear idea of how their relative was without any substances in their system.

Staff spoke about the people in the ward with care and compassion. When we met with staff, it was clear that they knew the people in the ward well and could provide all the information that we asked for. We saw staff interacting with people in a friendly, helpful, and professional manner.

Care, treatment, support, and participation

We heard from the senior manager that the unit is well staffed with the ability to recruit and retain staff; this has led to a stable staff team. When bank staff are required, it is usually the staff who know the service well who are available.

We heard about the complex physical health needs of the people in the ward and how this has had an impact on their mental health treatment. It was clear that the ward team took a multi-disciplinary approach and regularly involved other medical professionals. We heard from families and from staff about joint working between mental health and general health services and the involvement of people, their families and carers in this.

The IPCU is situated in the general hospital. The ability to refer people to medical and surgical services, and the ability of colleagues to review people in IPCU due to the availability of the medical emergency response team when people were acutely physically unwell is clearly of benefit to the people in IPCU.

We heard that the mental health service, which the IPCU is a part of, has a daily service 'huddle' meeting attended by senior charge nurses from all the mental health units. At this meeting, levels of illness and risk across the site are considered and a plan made for the day with regards to staffing levels, experience and the mix of staff across the service to ensure a flexible approach to service demand each day. This meeting also gives senior staff the opportunity to discuss referrals into the IPCU, with consideration of referral criteria to the unit, and allows people's care to be prioritised according to their clinical needs.

The recommended maximum admission to IPCU is 12 weeks. Three people had been in the IPCU for over 12 weeks and one person for approximately 18 months. When we discussed care and treatment, it was evident that the team had a positive person-centred approach and were flexible in their approach to best meet the individual needs of each person.

The mental health service also has a monthly 'morbidity and mortality' meeting where momentous events were discussed by medical professionals. The focus of this meeting is to ensure that there is learning from events when a more formal review process is not indicated. There is an intention to broaden the attendance at this meeting to support a multi-disciplinary approach.

We were told that there were no outstanding complaints or significant adverse event reviews relating to IPCU at the time of our visit.

Care records

Information about a person's care and treatment was held in an electronic record system called Morse and additional information could be found on the Clinical Portal. Medication was prescribed via an electronic system called HEPMA. Some information was also held in paper in folders. There was a folder containing all legal paperwork, and an additional folder that held admission paperwork, patient demographics, physical investigations, and clinic letters relating to physical health care.

We reviewed the care plan documentation on Morse. Each person had one care plan with a different section for each individual care need. We found that care plans contained a wide range of information which covered both mental and physical health care needs. In each section of the care plan a different area of focus was considered, such as maintaining a person's mental health, and in this, a number of factors considered including supporting compliance with medication, the use of

specific medications, and the use of legislation. Care plans were regularly reviewed, and the dates of reviews formed a list after each section in the care plan. Where reviews were recorded at the end of each section it was not always clear which specific aspect of that section was being reviewed. We also saw that reviews frequently noted that no change in the person's care plan was required, without any additional detail or rationale provided.

We discussed the care plan document and the issues we found with senior staff. We recommended that the care plan documentation is updated, with a view to individual care plans for each specific care and treatment need, reviews that focus on each specific outcome or goal and recording at the time of the review of the rationale for any decision made. Where changes are made to the care plan after a review the specific change should also be recorded.

Recommendation 1:
Senior managers should review care plan documentation to ensure that care and treatment needs are separated into individual care plans. The intended outcomes should be included in care plans with progress towards these documented over time.

The Commission has published a good practice guide on care plans[1]. 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.

In addition to care plans, we reviewed the daily continuation notes which were completed during the day and at night. These summarised the person's mental state, any changes in their presentation, activities that they were offered and their ability to participate in them.

We saw that nursing staff also regularly recorded when they spent time with a person on a one-to-one basis and what they did during that time.

We reviewed a range of other documentation that was available. This included information about the person's health, physical health recordings, dietary screening tools, side effect screening tools, and alcohol and domestic violence screening tools.

Risk assessment documentation was also reviewed. The risk assessment and management plans were in the form of a traffic light system which contained detailed background information and information relating to historical and current risk. Risks included mental health, physical health, and risk to self. For each person, an overall risk category was recorded, and this was revised over time. We found the risk documentation easy to read and the coloured risk groups easy to understand.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Ward staff also complete an additional SBARR (Situation, Background, Assessment, Response, Review) form on admission and then on a weekly basis for each person in the ward. This appeared to act as a summary of the reason for admission and to record progress each week. We asked about the purpose of this form during our visit as it appeared to duplicate some of the information in the weekly multi-disciplinary meeting minutes. Senior staff told us that they would consider whether this form continued to be required.

Multidisciplinary team (MDT)
The unit has multi-disciplinary input including psychiatry, psychology, occupational therapy, dietetics, and pharmacy. There is also a resident doctor.

We saw detailed minutes from the weekly multi-disciplinary meetings in each person's electronic care records. These included a range of information relating to the person's mental and physical health, medication, and legal status. Additional background information was also included, and we found this helpful. The minutes of the MDT recorded who attended the meeting from the ward team, the person, family members and carers and, where appropriate, social work teams. An additional section recorded the views of the person. The involvement of allied health professionals and liaison with the local mental health team were also included.

In the electronic care records, we saw assessments, risk assessments, screening tools and additional care plans that detailed the involvement of allied health professionals in the person's care and treatment.

In the electronic medication prescription system HEPMA, we saw pharmacy care plans for each person. Where people had physical health conditions that had an impact on their medical treatment, or where they were prescribed medications that required more intensive monitoring, we saw care plans in paper and electronic files to support this.

Use of mental health and incapacity legislation

On the day of the visit, five people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and one person was subject to the Criminal Procedure (Scotland) Act, 1995.

All legal documentation was held on the electronic records but a folder for each person was also kept in the office containing all of the legal paperwork. This was readily accessible, organised and all documentation was accurate and up to date.

Care records detailed that people had been informed of their rights and provided with relevant information. Information about mental health was also displayed in the IPCU.

We were told that people could access advocacy by referral and were provided with information about this by the ward team and by Mental Health Officers. One person spoke to us about having contact with advocacy in the past but did not feel that they needed this now.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. The T3 paperwork was held in the legal documentation folders making it readily accessible. It was also helpfully documented on the electronic care records and HEPMA prescribing systems, with alerts to notify staff of their use.

We discussed one medication prescription that was appropriately included in a T3 where we considered that additional detail may be required to more accurately authorise its use, given the length of time that it had been prescribed. The responsible medical officer was going to follow this up after our visit.

At the time of our visit, one person had increased levels of care in relation to their presentation. The enhanced observation levels were recorded in the care plan which was reviewed every few days. It was not always clear which aspects of the care plan were the focus of the review as each section could include more than one aspect of care and treatment.

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. Whilst none of the people that we reviewed had a named person, it was recorded in the mental health act documentation that this had been discussed with people.

For those people that were under the Adults with Incapacity (Scotland) Act, 2000, (AWI Act) this was included in the alerts in both the paper and the electronic records, and the documentation was available in the legal folders.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We reviewed section 47 certificates in the legal folders and found these were appropriately completed.

Rights and restrictions

The unit operates a locked door policy, in keeping with the needs of the people receiving intensive treatment there. We heard that four people were able to go out from the ward at the time of our visit. Two people were not able to leave the ward due to their mental ill health, but they were able to access an adjacent courtyard if they wished.

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 are introduced, it is important that the principle of least restriction is applied.

Two people were specified persons at the time of our visit. We reviewed the relevant paperwork and found that the necessary documentation was in place, that a clear rationale was recorded, and that individuals had been informed and were aware of their rights.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 did not find any advance statements during our visit. We saw that there was a section in the multi-disciplinary meeting minute to record whether or not the person had made an advance statement. When we discussed advance statements with medical staff, we were told that the people who had capacity to make an advance statement had declined to do so.

One family spoke to us about the distress that their relative experienced when they opened correspondence from solicitors and about their benefits. The family had just been granted Welfare Guardianship powers under the AWI Act for their relative. When we discussed this issue with the ward team, they advised us that there was a meeting the next day with the person's family, and they would come to an agreement then about how to manage this issue.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

On the day of our visit, we heard about a range of activities that people were offered and could take part in. This included one-to-one activity with staff, group activities in the ward and community activities.

One person told us that they would like to have more to do but was then able to tell us about the regular activities that he took part in. One person was out at a gardening group when we visited and when he later returned, he told us about going bowling with support from staff and the walking group he would attend the next day.

One family told us that they didn't always know how much their relative was doing as the person was not always able to tell them. The staff team had provided updates about the person engaging in crosswords with them. The person had also been able to go out to sit in the courtyard with a member of staff but had declined to go for a walk. The family told us that the staff would upload new music to their relative's portable music player so that they had music to listen to.

In addition to the activities mentioned above, we heard about a ward cooking group which people regularly took part in. The ward has an activity cupboard with a range of games and craft activities. There is a gaming console on the ward and people can watch TV and listen to music. There is a table tennis table, and the quiet room has gym equipment.

People can also go out for walks, access the hospital café and be supported to go out into the community. The ward can access a minibus and use this for other outings.

In care records we saw a range of assessments with regards to individual's ability to manage their personal care and undertake activities of daily living. We also saw individual risk assessments to support people going out in the car and out to community venues where clinically indicated.

The physical environment

The IPCU is accessed by locked double doors through a locked reception area. There is a family room in the reception area that was clean and bright, with a table and chairs. The ward has a main central corridor with office space, meeting rooms and dining and living areas along each side.

The bedroom area is at the end of the corridor. We saw one bedroom and it was bright and clean.

In previous visit reports, concerns were raised about the need for windows to be replaced due to the magnetic blinds falling down. As an interim measure the windows had been frosted to provide some privacy. Future work to replace the windows is intended however work to replace the en-suite doors is being prioritised;

these will be replaced with doors that have sensors on the top. The sensors would alert staff if anything were placed over the door to reduce risk in relation to ligatures.

We heard from senior staff that the IPCU courtyard had been out of action whilst ducting was installed, due to work in an adjacent department. Since the ducting was installed the IPCU courtyard, it has become littered with droppings from the pigeons that sit on the ducts and the courtyard has been closed due to infection risk. Several solutions are being considered with some concern about how this may impact on the people in IPCU. As an interim measure people in IPCU can use an adjacent courtyard. We could see this courtyard from the IPCU. It was a well-maintained and welcoming space with shrubs and seating areas.

One family told us that they had not seen their relative's bedroom and that they were worried about whether the bedroom was comfortable or not. They also volunteered to bring things from home to make the room more homely. This was not an issue that they had raised with the ward team. We spoke to the team about this, and they intended to ensure that these issues were addressed.

Summary of recommendations

Recommendation 1:
Senior managers should review care plan documentation to ensure that care and treatment needs are separated in to individual care plans. The intended outcomes should be included in care plans with progress towards these documented over time.

Any other comments

The unit is working towards Quality Network Accreditation from the Royal College of Psychiatrists and are currently in a period of developmental membership with the aim of accreditation in three years' time. As part of the developmental process, the multi-disciplinary team have created patient & carer information and a feedback process for people, families, and carers. Work has already been completed on documentation to support referral processes including criteria and a checklist for referral.

Service response to recommendations

The Commission requires a response to the recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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