Mental Welfare Commission for Scotland

Report on announced visit to: Ravenscraig Ward, Whyteman's Brae Hospital, Kirkcaldy, Fife, KY1 2ND

Date of visit: 23 January 2020

Where we visited

Ravenscraig Ward is a 29-bedded adult acute admission unit in Kirkcaldy, Fife. It is a mixed sex ward comprising of four six-bedded bays and five side rooms. It covers the catchment area of central Fife and is covered by five psychiatrists.

On the day of our visit there were 28 patients. We last visited this service on 12 February 2019 and made recommendations in relation to care plans needing to be person centred, reviewed regularly and audited appropriately. In addition, we recommended the need for audit of individual risk assessments and a review of the ward environment, in particular in relation to patient safety. We received a response and follow up action plan to these recommendations within three months.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision, and discuss admission criteria. These themes were identified on our last visit and have been brought to our attention by past patients and family members. This was an announced visit.

Who we met with

We met with and/or reviewed the care and treatment of eight patients on the day. There were no relatives or carers who wanted to meet with us on the day of the visit.

We spoke with the lead nurse, senior charge nurse (SCN), other members of the nursing team, and the occupational therapist. As detailed above, bed spaces were full and the SCN highlighted that there were two patients who were boarding within the ward from other areas within Fife.

The SCN advised that recruitment and retention of staff continues to be an issue. The ward still has a number of nursing vacancies and employs supplementary staff. The SCN stated that these tend to be the same core group who know the ward well and can provide ongoing consistent care. The SCN also advised that the service is hoping to employ an additional charge nurse on a temporary basis. It is anticipated that this role will support the SCN in the leadership and management of the ward.

The SCN commented that Ravenscraig Ward can have a high number of admissions and turnover of patients, given its location in central Fife. It admits patients between the ages of 18–65 years. We were advised that there is no admission policy or identified criteria for the ward but this is currently being developed and a draft document is in place.

Commission visitors

Paula John, Social Work Officer

Philip Grieve, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We spoke to and reviewed the records of eight patients. Most of the patients stated that they were happy with their care and treatment. Some, however, were unhappy about the number of patients in the ward and explained that the nurses were all extremely busy. They said that when they need to speak to a nurse staff will always make time to speak to them.

However, there was a view that nurses tended not to approach patients to offer structured one-to-one engagement as they were often busy with other tasks. Patients require to seek staff out.

All patients stated that they see their doctor regularly and this was evidenced in their care records. There are five consultant psychiatrists covering the ward each holding a weekly multidisciplinary team (MDT) meeting. On our last visit concerns were raised about the number of locum doctors which was impacting on consistent patient care. Of the five psychiatrists, two are locum doctors; however, we were advised that they have remained with the team for some time.

The recording of MDTs was found within the progress notes of each patient care record. On our previous visit the ward was piloting the SCAMPER document which was being used to review the progress of care and treatment with each patient. We understand that this document is no longer being used. Although MDTs were being recorded, they were difficult to locate within a lot of other paperwork. It was also not always clear if patients and their families were in attendance and what their views were. The clinical team may therefore benefit from considering a structured template which reflects all views and accurately records the MDT meetings.

We were pleased to hear that there are now two occupational therapy (OT) staff in place who provide dedicated input to the ward one day a week. Presently, they are providing the breakfast group and an activity class but hope to develop and expand the level of meaningful activity for patients. Although this service is now in place some patients did comment that they felt bored on occasion and had little to do.

On our last visit, we identified that where psychological therapies are required for individual patients, they will be referred directly to the community-based teams. Clinical psychology will respond accordingly and in line with individual needs. This is still the case, but we were also told by staff that visits by psychology can be made to the ward and engagement is not solely community based.

We queried if nursing staff have the opportunity for training in psycho-social interventions and were advised that NHS Fife is investing in Decider Skills training which aims to assist patients in recognising their thoughts, feelings and behaviours, and develop strategies to manage their own mental health. Currently there are six trainers for NHS Fife, one of whom is a charge nurse on Ravenscraig Ward. This initiative has not begun yet, but it will be rolled out across the service and audited for effectiveness.

We also reviewed individual care plans, and again found inconsistencies in their completion. Not all care records had the same documentation, and while some had completed standard documents, others were blank. There was no evidence of the patient being involved in the care plan, they lacked a person-centred approach with limited evaluation or review. Again, the lack of participation and personal views was a consistent theme. Where individual care plans existed, we found them to be quite general and read as a list of statements as opposed to achievable interventions with outcomes. We could find no care plans that had been signed by patients.

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

The ward continues to use the standard "Working with Risk" document, as used across all of NHS Fife mental health services. Similar to our last visit, there remain inconsistencies in the completion of this document. We were advised by the SCN that work is being undertaken on a new risk assessment tool. The new document is awaiting launch and is more focused. The current document is lengthy and comprises two levels of risk assessment. The aim is that this new tool will improve completion and overall risk assessment. There was little evidence to demonstrate patient participation, and identified actions and interventions to minimise risk appear not to have been shared with the patient. In addition there was little evidence that demonstrated a link between the risks identified and the current identified care plans. There was no evidence of a review of the risks and they did not translate into a risk management plan.

In discussion with nursing staff that we spoke to they said that the team works really well together and all professionals have a good working relationship. We witnessed kind and caring interactions from nursing staff and healthcare assistants on the day of our visit.

Recommendation 1:
Managers should ensure that care plans are regularly audited, consistently completed, person centred, and regularly reviewed.

Recommendation 2:
Managers should ensure that risk assessments are audited regularly to ensure full completion as identified within local guidelines.

Use of mental health and incapacity legislation

The majority of the patients we spoke to were informal. Of the patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), we were able to locate appropriate paperwork within the care record. It was clear from the records where compulsory measures were in place, and the use of the Mental Health Act Best Practice document assisted this.

We looked at consent to treatment under Part 16 of the Act and were able to locate certificates (T2 and T3) for all patients who required these. All (T2) certificates were in place and we did not find any irregularities.

For those detained patients incapable of consenting to specific treatments we found that certificates were not in place for two patients and there was a wrong medication identified within another (T3) treatment form. We were able to address these issues with the relevant doctor on the day.

Recommendation 3:
Managers should ensure that there is a regular audit to ensure the appropriate authorising treatment forms are accurate and in place.

Rights and restrictions

We were advised that the door to Ravenscraig Ward remains locked at all times due to identified hazards and risks located in and around the building. Patients and visitors can enter by a buzzer system and leave by asking a member of staff. Patients who we met on the day who were not detained advised that they were aware that they could leave the ward while always notifying staff. A locked door policy was in place.

The majority of patients we spoke to were unsure of their rights, both formal and informal. Several patients explained that they can remember being given information on admission but couldn't remember the detail; other patients explained that they were unaware of any information being shared with them.

Few patients had advance statements and staff advised that there was a low take up on these. Advocacy services are in contact with the ward and we aware of them visiting on the day.

Recommendation 4:
Managers should ensure that all patients who are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, and those who are informal, are aware of their rights when they are in hospital.

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

Activity provision continues to be a challenge for the ward. We found little evidence of structured activity with no identified ward programme and no weekly planner on the notice boards. The SCN advised that until recently it had been difficult to provide a weekly programme given a lack of OT provision and nursing vacancies. There was indication of a games night and walks out with the ward but patients reported that there is little to do and this is heightened during the evenings and weekend. Recording of activities was also difficult to locate on the records, especially where this had been offered but refused.

We were pleased to see that the ward now has two occupational therapists who visit the ward once a week and we look forward to hearing how this work will progress in the near future. In discussion with these staff members however, it was clear that they have to cover a large catchment area in addition to the ward.

The SCN explained that she is involved in the implementation of "From Observation to Intervention" and "Improving Observation Practice "developed by the Scottish Patient Safety programme. This work aims to develop observation practice by looking at more therapeutic activity for acutely unwell patients. It is hoped that this will contribute to an overall improvement in activity provision within the ward. We noted that there has been no progression of an activities co-ordinator since our last visit.

Recommendation 5:
Managers should ensure that a range of meaningful activities are available for patients to participate in and should be recorded appropriately within the care records.

The physical environment

The physical environment of Ravenscraig remains problematic. It comprises of a reception area which is rather unwelcoming and smelt of smoke on the day of our visit. The reception area itself is not staffed and in addition to the access door to the ward there is an interview room. This interview room is also used by the unscheduled care team who will complete assessments here, and Police Scotland when they bring patients to the ward in crisis. The space appears cramped but notably had been redecorated since our last visit and new furniture provided. This is a busy thoroughfare not only for visitors, but patients have to walk through this area for meals, at breakfast time many are in nightclothes and there is no privacy.

The main ward area remains cramped with limited communal areas for patients and poor meeting and interview space for staff. It was noted that the walls have been painted within the environment which has made a slight improvement to appearance. Work has now progressed to minimise potential ligature points throughout the ward. However, the ward does retain a more clinical appearance and would benefit from softening with the potential use of patient art/pictures.

We were pleased to see the discharge tree mural on the wall and evidence of progression through the "safe wards" approach.

The dormitory spaces have space for personal belongings and patients can access showering facilities per dormitory.

The areas identified for creative work and art led off the main corridors creating blind corners and was not conducive for effective nursing observation. These rooms were also cramped with large amounts of items in storage.

The dining room, as highlighted above, remains situated off the ward area and patients have to access this via reception.

The garden area remains unsecure and would benefit from additional attention. We were advised that the ward team have submitted a request to extend the boundary of the garden

which would allow an alternative access point and increase security. We were pleased to hear this and noted that the back fire door allows access to a steep set of concrete stairs and a ramp. This door can be accessed by any patient, and we were advised that a number of patients have attempted to leave through this door. The door is alarmed and, when opened, there is a prompt response from staff. This in our view continues to remain a risk, particularly to vulnerable patients.

Recommendation 6:
Managers should address patient safety concerns in relation to the ward environment.

Recommendation 7:
Managers should ensure that the upgrade programme is regularly reviewed, and that attention is paid to the garden area and communal areas.

Summary of recommendations

1. Managers should ensure that care plans are regularly audited, consistently completed, person centred, and regularly reviewed.

2. Managers should ensure that risk assessments are audited regularly to ensure full completion as identified within local guidelines.

3. Managers should ensure that there is a regular audit to ensure the appropriate authorising treatment forms are accurate and in place.

4. Managers should ensure that all patients who are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, and those who are informal, are aware of their rights when they are in hospital.

5. Managers should ensure that a range of meaningful activities are available for patients to participate in and should be recorded appropriately within the care records.

6. Managers should address patient safety concerns in relation to the ward environment.

7. Managers should ensure that the upgrade programme is regularly reviewed, and that attention is paid to the garden area and communal areas.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report

Given that several of these recommendations were also made in our two previous reports, we will also send this report to the chief executive officer in NHS Fife for comment.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON

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 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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