Mental Welfare Commission for Scotland

Report on announced visit to: Lomond ward, Stratheden Hospital, Springfield, Cupar KY15 5RR

Date of visit: 4 March 2020

Where we visited

Lomond Ward is an adult acute admission mental health unit which has 30 beds. It is located in the grounds of Stratheden Hospital and covers the Glenrothes and North-East Fife areas. It is a mixed-sex ward and comprises of six single rooms and four six-bedded dormitories. There are five consultant psychiatrists attached to Lomond Ward all in permanent positions. Lomond Ward also provides admission beds for the community forensic mental health team. On the day of our visit there were no vacant beds and the ward was full. This was an announced visit.

We last visited this ward on 25 October 2018 and made recommendations in relation to care planning, auditing of authorisation of treatment, activities and the ward environment. We received an updated action plan on these.

On the day of this visit we wanted to follow up on previous recommendations and also give patients, their families, friends and carers the opportunity to raise any issues with us. We also were keen to look at the following areas: safety and security on the ward; meaningful activity, and physical environment

Who we met with

We met with and/or reviewed the care and treatment of eight patients on the day of the visit. Unfortunately, there were no relatives, carers or friends who wished to speak to us.

We also spoke with the lead nurse, senior charge nurse (SCN), and other members of the nursing team. We also met individually with the ward activity co-ordinator and briefly met with one consultant psychiatrist who was on the ward and made himself available.

Commission visitors

Paula John Social Work Officer

Philip Grieve Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients that we spoke to on the day told us that they had good relationships with nursing staff and felt that they made a positive impact on the day-to-day care that they received. In some cases, patients who had experienced past admissions to the ward, advised that they noted an improvement in staff attitudes and overall support. Staff making individual time for patients and the recent introduction of additional activities were two examples given. We observed some of these activities taking place and the majority of patients were up and dressed. We discuss this further on in the report. There were still comments however, that staff appeared to be busy and stretched at times.

Patients were clear that they had a named nurse and most could confirm that they had a care plan. Some patients that we spoke to had some understanding of what this contained. There were two comments made in relation to ward meetings in that, these could be large and intimidating at times, often comprising of a number of professionals. Comments were also made that because of the set-up of the room, that patients were sometimes sat at the head of a large table which added to a feeling of unease. We spoke to the SCN about this issue and she was able to confirm that it is customary for doctors to discuss with patients who they would wish to be present at their meetings. She agreed to raise this issue further with the psychiatrists visiting the ward.

With five psychiatrists attending Lomond Ward, patient comments on accessibility and communication with their doctors was variable, but all were having weekly contact. In summary, we found patient views were generally more favourable, than on our last visit. Comments on staff attitudes and added structure to the ward were encouraging.

In relation to multidisciplinary team (MDT) meetings, these took place weekly and were attended by doctors, nurses, social work staff and pharmacy. Occupational therapy (OT) and psychology services are also available by referral and will attend the meeting when required. We had been advised by managers that this situation was under discussion and that additional resource could be provided to the ward, but this is still under review. We were advised that OT services at present provide a full assessment service but are not routinely involved in meaningful activity programmes on the ward.

Participation by patients and family members is evidenced within both the nursing care plans and the medical records. This to us represented duplication of work and there has been no development on producing a recording or review tool for the MDT meeting. NHS Fife had previously been piloting the SCAMPER document, but we have been advised by managers that this is no longer in use.

There is no admission policy for the ward currently, but we were advised that this is in draft form. The boarding out of patients to other wards both on the Stratheden hospital site and other hospitals is also being considered, and a policy being developed. On the day of the visit there were no patients boarding out to other wards or patients admitted from other areas in Scotland.

We were advised that there were three patients who met the criteria for delayed discharge, one who had been there for nearly two years. We will continue to monitor this situation.

Care planning still requires some attention specifically around their development and patient participation. We found the care plans clear and well indexed with a range of differing paperwork. Most patients were aware of a care plan but were not able to fully articulate to us how this linked to their recovery. The plans were not always person-centred, but there has been some improvement in this area since our last visit. Some of these plans therefore lacked meaning or indeed value.

There was evidence that patients had signed the documents. However, it was clear that the plan of care had already been devised and documented by nursing staff and patients asked to counter sign. Interventions remained fairly prescriptive but we did see evidence of one-to-one sessions taking place. With regard to risk assessments, the 'Working with Risk' document which is standard across all admission wards, was fully complete. However, as commented upon in previous reports there is a lack of connection to individual risk and the care planning process. Overall documentation was fully complete with good evidence of review. Despite these comments we felt that solid auditing of care plans, which includes regular data and review could help improve this situation. It was also clear that improvement is being steadily made in this area over the course of our last visit.

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

Recommendation 1:

Managers should ensure that care plans are audited regularly to ensure that they are of a high standard with a focus on person centred care and recovery**.**

Use of mental health and incapacity legislation

We were able to locate the relevant paperwork for all patients subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and this was completed appropriately. This paperwork was also contained in case notes and was filed and easy to locate. Just under a third of patients on Lomond Ward were subject to compulsory measures. There was some evidence contained within the case notes that rights were discussed. NHS Fife also has a Mental Health Act best practice form which documents a patient's pathway when detained. What was less evident was discussion in to advance statements

In addition, we looked at certificates to authorise treatment both under the Mental Health Act (T2 and T3). These authorise medical treatment where an individual is not able to or not giving consent. We found no issues that required addressing on this occasion. We were advised that there is pharmacy input to the ward to assist with this issue.

We found no issues with s47 paperwork of the Adults with Incapacity (Scotland) Act 2000 which are in place where an individual is incapable of giving consent to medical treatment.

Rights and restrictions

Lomond Ward has a locked door and this is controlled by a reception area at prescribed times during the day, and by nursing staff at times out with these. The door is electronic and all patients have a care plan in relation to time off the ward. Staff advised that primarily, the locked door has been implemented as a safety measure, and to monitor visitors. There is a policy in place, but it was not clear how frequently this is reviewed.

The garden area at the back of the ward is also enclosed with a high wooden fence, this again is to prevent detained patients leaving the ward and for added privacy.

We were advised that there were no patients subject to a continuous intervention during the day of our visit. The floor nurse scheme is still in operation, but this has been revised and now not only oversees detail of patients on the ward, but also nursing interventions.

We were advised that advocacy services are regular visitors to the ward and that patients are informed of their rights. We did note some gaps in rights based care in relation to information on named persons and advance statements, but this did not apply to all patients.

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 were advised by the SCN that since her recent appointment, she has reviewed the activity provision on the ward and created an activity co-ordinator post. We were able to speak to the member of staff providing this service. She provides activity input from 9.00am until 3.00pm each day, including a programme for the weekends. She is assisted in this role by other members of the nursing team. An activity planner is in place and interventions are planned on 5 sessions each day at 10.00am, 11.00am, 1.30pm, 3.30pm and 6-30pm. These are designed to be flexible to the needs of patients.

We were advised that there is no specific budget for this, but activities include art and crafts, baking, walking groups a let's talk group and healthy eating. All staff on the ward are undergoing training in Decider Skills and these are also being applied in a group setting.

Activities are also taking place off the ward but staff have limited access to transport, which is one vehicle shared across the hospital site.

There is a large activity room on Lomond Ward, which is now being used and we were able to observe a number of groups taking place throughout the day. A number of patients in interview advised us that this has been a welcome addition to the ward and is contributing to their recovery.

We were encouraged to see this development and welcome this, as we are aware it has been difficult to provide a service in past months, in light of staffing constraints. While we were advised these remain an issue, the activity co-ordinator role has been a positive addition to the ward.

Recommendation 2:

To promote the progress of the activity programme managers should look at how they could support this initiative further either through resources or provision of transport.

The physical environment

Lomond Ward is a large space comprised of two wings separated by a reception area. Efforts have been made to brighten up the reception area and it does feel more welcoming. We particularly liked the discharge mural tree and the staff information board which provide colour and information for visitors.

The clinical ward area of the building continues to have six side rooms and four dormitories. It also has a dining room and living room. We were advised that some refurbishment work to ensure safety on the ward has now been completed. The SCN has reviewed the space in the clinical area and has relocated the nursing office to a larger space. This has benefitted the ward team and led to an increase in morale. The SCN nurse office has also moved centrally within the ward to enhance patient and staff accessibility.

The dining room remains problematic for staff as it leads directly to the garden, where some patients continue to smoke. This creates a strong smell of smoke at the far end of the ward and where other patients eat. The SCN advised that the hospital site will be totally smoke free and they have begun to work on this issue. There are also proposals to look at some refurbishment of the dining room in the future.

The non-clinical side of the ward contains interview rooms, the art/activities room and a relocation of a physical health check space for doctors. Nursing staff also now have a space for breaks and lunch. There has been a marked improvement in general tidiness and new chairs, paintings and posters are evident.

We were informed that the current safety alarm system was not working properly and this was a significant patient and staff concern. It has been reported to estates and we would expect a timely response for repair/replacement in order to keep staff and patients safe.

Recommendation 3:

Managers must ensure that the alarm system for the ward is repaired as a matter of priority.

Summary of recommendations

1. Managers should ensure that care plans are audited regularly to ensure that they are of a high standard with a focus on person centred care and recovery**.**

2. To promote the progress of the activity programme managers should look at how they could support this initiative further either through resources or provision of transport.

3. Managers must ensure that the alarm system for the ward is repaired as a matter of priority.

Other Practice Issues

We were advised by the SCN that there are current issues with dispensing of medication particularly for those patients awaiting discharge or leaving the hospital for periods of leave or suspension of their detention. Currently we are advised that a 72-hour notice period is required for pharmacy services and this can limit leave on occasions. It was not clear from speaking to the lead nurse or SCN why this would be and we accept that this maybe a situation out of managers control. However, we feel local discussion on this area would be helpful, with feedback given to ourselves and the SCN.

In addition, we were advised that draft policies, some of which have been developed as an outcome of significant events, can be delayed for a 2-3 month period due to discussion between varying professionals. We cannot comment on this but would suggest that this is an issue for local governance mechanisms to pursue.

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.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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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