Mental Welfare Commission for Scotland

Report on announced visit to:

Mid Argyll Hospital, Succoth Ward, Blarbuie Road, Lochgilphead, PA31 8JZ

Date of visit: 14 June 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Succoth Ward is a 14 bedded adult admission ward on the ground floor of Mid Argyll Hospital in Lochgilphead. There are two four bedded bays that have been out of use during the pandemic. Care in the ward is overseen by four consultant psychiatrists. On the day of our visit there were 14 patients on the ward. We heard that this ward consistently operates with high occupancy levels.

On our last visit to the ward in 2019, we made recommendations in relation to: clinical psychology; forensic pathway; and activity provision.

On the day of this visit we wanted to meet with patients, and review progress with previous recommendations since our previous visit.

Who we met with

We met with and reviewed the care and treatment of eight patients and spoke with one relative.

We spoke with the service manager, the clinical operations manager, the senior charge nurse (SCN) and with other nurses working in the service. We also met with advocacy services separately.

Commission visitors

Douglas Seath, nursing officer

Lesley Paterson, senior manager (practitioners)

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

The patients we spoke to on the day were satisfied with the care and treatment provided in the ward and overall, were complimentary about the staff involved in their care. They reported that they felt involved and included in discussions about their care and treatment and this was echoed by the relative we spoke to, who highlighted good communication between themselves and the care team and, we heard that they couldn't fault the care being given. The senior staff appointed to the ward are fairly new in post and keen to establish a ward culture conducive to progressive ideas and patient involvement. We look forward to seeing the benefits of this enthusiasm on our next visit to the ward.

Some of those we spoke to thought that it would be better if there were more activities on offer throughout the day and if there could be an improvement in the food that was offered. We discussed these with staff on the day of our visit; we were advised that prior to the beginning of the pandemic, there had been opportunities for ward staff to develop and provide a range of activities in the ward. However, as the restrictions associated with Covid-19 have now lessened, there was a return to patients engaging with occupational therapy (OT), and an increase in-group work, though activities provided by the nursing team are still dependent on staffing levels. In discussion with the SCN, we heard that there are likely to be developments in the coming months regarding the development of an activity co-ordinator role in Succoth Ward. Clinical psychology provision has been hampered by difficulties in recruitment but we heard that this should be eased somewhat by a new appointment taking up post in the near future. In relation to food, we heard that variety is about to expand with a move to a three week rota.

Care planning and documentation

The care plans in Succoth Ward provided a comprehensive account of the patient, their mental health and the contact the staff have had with them on a shift-by-shift basis. There was clear evidence that care is formally reviewed by the multidisciplinary team (MDT) in collaboration with the patient, with associated outcomes and actions noted. We also noted that the care plans better reflected the goals of each patient, and while the care plans primarily focused on the acuteness of the patient's mental health, these were reviewed regularly, with clear opportunities for the patient to express their views and for the patient to sign, giving their consent.

We were pleased to hear that there is ongoing audit of care plans, and that this is reported back to the clinical operations manager, who continues to monitor this. The Commission has produced Good Practice Guidance on person-centred care plans which can be found at: https://www.mwcscot.org.uk/node/1203

Use of mental health and incapacity legislation

On the day of our visit, there were a number of patients in the ward that were detained under the Mental Health (Care and Treatment Act) (Scotland) 2003 ('the Mental Health Act') and some of those who were subject to specified restrictions. For those that we reviewed, the relevant paperwork relating to the Mental Health Act was available, along with forms for consent to treatment under the Mental Health Act (T2 and T3 forms). We found discrepancies in T2 and T3 forms with no signed consent in some, and prescriptions without authorisation

in others. We discussed these with staff on the day and were given the reassurance that these would be rectified as soon as possible.

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. Documentation in relation to the specified person measures was accessible and, other than one form to authorise restrictions on use of telephones, we found that these were up to date. The responsible medical officer was contacted after the visit to complete the required documentation.

Patients reported the difficulties involved in not being able to attend Mental Health Tribunals in person and how impersonal it is having to conduct a discussion by telephone. They were hopeful that with the lessening of restrictions this should be reinstated as far as is possible or at least given the choice.

Recommendation 1:

Managers should identify a system of auditing consent to treatment forms and specified persons forms in order to ensure any errors are immediately rectified so that treatment given and/or restrictions imposed are legally authorised.

Rights and restrictions

The main entrance/exit door to Succoth Ward is locked, although staff respond quickly to assist those patients who were able to, and request to, leave the ward. The pandemic has had an impact on individuals being able to leave the ward; however, where possible, access to the outdoors has been supported and when we visited, we observed patients being able to access the grounds of the hospital and/or go into town.

On the day of our visit, there was one patient who required increased levels of observation, and we were pleased to note that there was a care plan in relation to this restrictive practice in accordance with the Health Improvement Scotland (HIS) 'From Observation to Intervention' framework. All patients continue to have access to advocacy, albeit this has had to be adapted due to Covid-19 restrictions, and has not been through the usual face-to-face contact. Those that we spoke to who had requested input from advocacy had been able to do so either through an electronic device or via telephone. The advocacy service also said that they will be reinstating in-person meetings in future.

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

A timetable of structured activity provision is prominently displayed in the ward. Ward staff have responsibility for arranging a range of activities in the ward. There is a focus on providing meaningful activities which patients can engage in, but we did hear comments from patients

who felt there was a lack of variety in the activities available in the ward. We heard that they tended to spend a lot of time in their rooms because they did not feel the activities that were available were stimulating. There is no gym and no physiotherapy input and the only exercise available is via the signposted walk in the nearby woodland.

On our last visit we felt it was important that patients receiving care and treatment as inpatients had access to activities which provide stimulation, and also opportunities for physical exercise. The appointment of an activity co-ordinator will be a good opportunity to review and seek views on the kind of activity patients feel they would most benefit from, and to establish a programme able to be maintained regardless of staffing difficulties.

Recommendation 2:

Managers should review activity provision and look at how provision can be enhanced with the addition of an activity co-ordinator.

The Physical Environment

The environment is modern and pleasant, with rooms available in the ward. The ward was clean and bright on the day we visited and there was a quiet, calm atmosphere during all the time we spent there. There are two dormitories which have not been in use during the pandemic. However, due to the pressures for beds, these may need to be opened again as soon as it is safe to do so.

There is also a garden space outside which is easily accessible and provides patients with access to fresh air. All patients have their own en-suite rooms, and can access these throughout the day. There is a well- equipped OT therapy kitchen for home assessments and space for group work when it is deemed safe to recommence these.

Summary of recommendations

1. Managers should identify a system of auditing consent to treatment forms and specified persons forms in order to ensure any errors are immediately rectified so that treatment given and/or restrictions imposed are legally authorised.

2. Managers should review activity provision and look at how provision can be enhanced with the addition of an activity co-ordinator.

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
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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