Mental Welfare Commission for Scotland

Report on announced visit to:

Hollyview Ward, IPCU, Stratheden Hospital, Springfield, Cupar, Fife KY15 5RR

Date of visit: 25 August 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.

Hollyview Ward is an eight-bedded unit based in the grounds of Stratheden Hospital. It is an Intensive Psychiatric Care Unit (IPCU) and is therefore a locked ward. An IPCU provides intensive treatment and interventions to patients who present with an increased clinical risk and require a higher level of observation. The IPCU covers the whole of the Fife area and we were informed that there is currently a locum consultant psychiatrist for this unit and a consultant psychiatrist for the community service. We were told the locum consultant psychiatrist will be taking up a substantive post in the unit; the clinical team appreciate that this will enable patients to have a more consistent approach to their care and treatment, rather than relying on locum doctors.

We last visited this service on 14 December 2020 and there were no recommendations made at that time. On this visit we were keen to hear about how the ward-based team had navigated through the Covid-19 pandemic, the challenges for patients who had increased restrictions placed upon them and whether restrictions had an impact upon relatives and carers. We were also keen to hear about progress with the provision of psychology, as during our previous visit there was a 'test of change' underway to consider the value of a psychological model of care in the IPCU setting. Furthermore, patients admitted to this unit can present with increased levels of risk. For this reason we emphasised a need to include a subheading relating specifically to risk in records of the weekly multi-disciplinary team meeting. We were pleased to see that this has now been included and provides clarity on any specific issues relating to care and treatment.

Who we met with

We met with, and reviewed the care of, six patients. We also had the opportunity to meet with a relative during our visit.

We spoke with the service manager, the senior charge nurse (SCN), the lead nurse prior to our visit, and had further opportunities to meet with and listen to the views of the ward based team on the day of our visit.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

We spoke with a number of patients who were receiving care and treatment in Hollyview Ward. They spoke positively about the nursing team and felt the ward-based team were caring and thoughtful. A number of patients we met with had previous experience of being admitted to hospital; while some patients had positive experiences, for others, this was not the case. However, patients described feeling safe in Hollyview Ward, and we heard that they were given opportunities to attend meetings and engage in one-to-one sessions with their keyworkers.

Those that we spoke with told us that nursing staff actively sought out their views about what helps in their recovery and areas they are keen to see changes in; this was extended to their physical well-being and therapeutic activities. We were told the environment was considered therapeutic, and large enough for patients to have enough space to relax and if there was a keenness to socialise, there were activities that patients could participate in collectively. One patient described the environment as "four star" and hoped that every ward could be the same size and offer the same amenities as Hollyview Ward. There was however a recognition from patients that we met with that the nursing team were very busy; they can see there are times nursing staff are not able to spend as much time with them as they would like. This, we were told, is a source of frustration for patients; nursing staff also told us this is equally vexing for them too as they value the time spent with their patients.

When we last visited the service we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We were pleased to hear from the leadership team that regular audits of care records including care plans are part of a governance programme in Hollyview Ward. This ensures documentation held in a patient's care record is of a good standard and allows the ward-based leadership team to support nursing staff in their endeavours to work with patients collaboratively.

We were told during our last visit to Hollyview Ward there was a 'test of change' to include colleagues from psychology as an improvement initiative to support patients during their admission. This has been underway for around two years with staff and patients identifying the positive impact upon care and treatment. For staff, the inclusion of reflective practice with their psychology colleagues has given them opportunities to work with patients using a psychological formulation. For patients, they spoke of their care and treatment in a holistic sense with a focus upon on their mental and physical well-being. Staff described the positive impact of this, and consider that this helps to ensure a value-based approach to care and treatment, that promotes learning from patients.

We were pleased to hear of these positive developments and while care plans were in place for each patient, we would like to have seen more detail of how goals and interventions were agreed with patients. We would also like to have seen more evidence of how those goals were considered and where there was agreement with the care plan, then this could be signed by both the keyworker and their patient or relative, as appropriate.

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/node/1203

Multidisciplinary team (MDT)

The unit has a broad range of disciplines either based there or accessible to the service. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings, and provide an update on their views. This also includes the patient and their families should they wish to attend.

We were told there are a number of vacancies at present for nursing staff and a ward-based occupational therapist; currently the ward is dependent upon an OT from another area. While their input is valued, the ward team recognise the benefits in having their own dedicated full time OT, not only to undertake a variety of assessments, but to also help support nursing staff, to work with patients who may require input in relation to activity and occupation. Patients admitted to Hollyview Ward can present with mental ill-health and illnesses related to neurological conditions. For this reason having input from occupational therapy is considered essential. For patients who require input from allied health professionals referrals can be made to physiotherapy, speech and language therapy, dietetics and psychology.

Patients admitted to Hollyview Ward usually require a higher level of support and interventions during an acute phase of their illness; for this reason admissions to this ward do not tend to be lengthy. We were pleased to hear that communication between staff from Hollyview Ward and the patient's host ward continues throughout the duration of their admission. Staff are invited (virtually) to attend weekly meetings to hear of their patient's progress and estimated dates for transfer of care back to their host ward.

Care records

Information on patients care and treatment is held in the 'MORSE' electronic record system. We found patient's records easy to navigate. There was a clear focus upon individual patient's mental and physical well-being, with a number of assessments based upon physical health. Patients admitted to Hollyview Ward require assessment based upon their level of individual risk, which for a variety of reasons, cannot be safely managed in general adult mental health wards. We were pleased to see those risk assessments were reviewed regularly and amended as necessary. We were told the ward has a number of laptops available for nursing staff to use in order to update records, but also importantly those laptops can be taken to patients for one-to-one sessions with keyworkers. This enables care and treatment to be assessed and reviewed in 'real time' and offers patients opportunities to work with their keyworker collaboratively.

Use of mental health and incapacity legislation

On the day of our visit, all patients in the ward were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) legislation. A number of patients were also detained under the Criminal Procedures (Scotland) Act 1995. The patients we met with who were detained under the Mental Health Act had a good understanding of their detained status. For patients subject to the Criminal Procedures Act there were some concerns about

the length of time they were having to wait for court hearings. We asked service managers whether they had heard of the issues raised by patients and they reiterated that this was an issue, however felt it was largely something out with their influence. We were told all patients have access to legal representation and advocacy services. Advocacy provide regular input into the ward with a blended approach that includes in-person support or via telephone.

We reviewed documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWI), including certificates around capacity to consent to treatment. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) were in place however we were unable to locate one certificate authorising treatment (T3) under the Mental Health Act. We were told this had been an administrative error and the senior charge nurse had brought it to the attention of the patient's responsible medical officer (RMO). We reminded the ward-based team and the RMO of the legal framework to ensure patients who cannot consent to treatment have their treatment authorised under Part 16 of the Mental Health Act.

Recommendation 1:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular audits for compliance should be put in place.

Rights and restrictions

Hollyview Ward continues to operate a locked door, commensurate with the level of risk identified in the patient group; there is a locked door policy in place.

Since our last visit, Hollyview has an area within the ward that the team is considering adapting to provide a bespoke area for patients in distress who require to be cared for away from others for short periods. The intention will be to optimise space allocation and if possible provide a bedroom, sitting area, bathroom and access to its own private outdoor space. Currently guidelines to support patients include a seclusion policy to ensure patients are not subject to this restriction for any longer than is necessary with regular reviews from medical and senior nursing staff. There is a policy in place to provide guidance to the team, with an understanding that seclusion, as an intervention, is supervised, time-limited, and should be regularly reviewed with patients having access to staff support during those periods where seclusion is required. Patients nursed in seclusion will have access to their bedroom, sitting area and outdoor space when it is deemed safe to do so, with staff recognising the need for individuals to have access to fresh air, and that a comfortable space is essential in helping patients to regulate and ease their anxiety. We were informed this intervention was not in used often, as the ward itself has the ability to help and support patients during the acute phase of their illness.

On the day of our visit there was one patient requiring enhanced observation from nursing staff. This level of observation should ensure patients who require it are provided with opportunities to participate in therapeutic engagement that includes one-to-one with staff, or they are encouraged to undertake social activities with support. We were pleased to see evidence of daily reviews, which is important, as it is recognised enhanced level of observation

can feel intrusive; it is essential patients do not remain on this level of observation for longer than is necessary.

Where specified person restrictions were in place under the Mental Health Act we found reasoned opinions in place. 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.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 in the future. Health boards have a responsibility for promoting advance statements. The patients we spoke with were not aware of advance statements and we were unable to locate the associated paperwork in patient's files.

Recommendation 2:
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this. These discussions should be clearly documented in the patient's clinical notes and care plan.

We were delighted to see that the information technology (IT) suite has access to Mental Health Act documents, guidance for patients on a range of subjects and how to access the Mental Welfare Commission using QR Codes. We were told this innovative approach was driven by patients who were keen to have information on their mobile devices rather than on paper/hard copy forms and booklets. Nursing staff were keen to ensure patients were provided with information about their stay in hospital, legal status and how to access legal support. This new approach was seen as inclusive and environmentally considerate while ensuring patients were given choices on how they were kept up to date with their care and treatment.

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 are aware that during the pandemic restrictions were put in place meant and there was a limit on the number of visitors that the ward could have day-to-day. For this reason, the ward was able to purchase iPads to help support patients to keep in touch with relatives and people that were important to them. Given the restrictions in place at the height of the pandemic, and to a lesser degree over the past 12 months, the leadership team designated one of the sitting rooms, which had access to a secure garden, as a space for visiting relatives. This garden has been identified for further development as a sensory therapy garden. With help from staff and

patients, there are already plans in place to encourage planting, and furniture design to ensure everyone using the garden can experience an environment that promotes well-being.

Patients had access to a number of ward-based activities, including ones that promote movement and exercise. For those patients who prefer art and creative pastimes, these were available as either one-to-one or group sessions. In the ward, there was a range of gym exercise equipment that we were told was very popular. Other equipment was also available including table tennis and badminton.

The physical environment

The ward is bright, large and spacious. The facilities are modern and with access to two outdoor areas, this allows patients the opportunity to socialise or have space to relax away from others should they wish. There were a number of communal areas, different sitting areas, a kitchen, a new IT suite and gym. We were told the purchase of new furniture had helped the ward feel modern and comfortable.

We again raised the issue around acoustic damping. While we agreed it was a large modern space, it lacked essential sound proofing and as there were some patients with sensory issues or who experience overstimulation, we were concerned the environment may contribute to patient's inability to emotionally or physically regulate. We were pleased to hear that there is an intention to consider using materials on the walls to enable soundproofing and to include purchasing specialised paint that is used in settings where there are individuals who require a non-stimulating/sensory-reducing environment.

Summary of recommendations

Recommendation 1:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular audits for compliance should be put in place.

Recommendation 2:
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this. These discussions should be clearly documented in the patient's clinical notes and care plan.

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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