Mental Welfare Commission for Scotland

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

Date of visit: 9 January 2023

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.

On the day of our visit, Ravenscraig Ward had 29 beds, providing acute mental health assessment for those between the ages of 18 and 65 years. Until recently, the ward was a 21-bedded unit, with bed numbers having been reduced as part of pandemic management. However, there had been a recent increase, with additional beds being placed in the dormitories.

We last visited this service on 30 September 2021 and made recommendations in relation to person-centred care planning, record keeping, including auditing of risk assessments, mental health act legislation and the need to ensure specified persons procedures were legally authorised. As with previous reports, we again had recommended that managers needed to address ongoing environmental issues relating to patient's safety, privacy and to update fixtures and fittings. We received a response from the service that included an action plan for all recommendations and dates for completion.

On the day of this visit we wanted to follow up on the previous recommendations and to hear how patients and staff have managed throughout the last year, we are aware there are still issues related to the pandemic and this will likely be ongoing for a period.

As at the time of our last visit to the service, we also wanted to find out if there had been progress made towards updating the environment; we were keen to see if there had been investment in the ward to make it more comfortable for patients, their visitors and staff.

Who we met with

We met with, and reviewed the care of seven patients, three who we met with in person and we reviewed the care notes of all seven. As this was an unannounced visit to Ravenscraig, we were unable to meet with patient's relatives on the day however we informed the ward-based team we would be happy to speak with relatives following the visit, and provided our contact details.

We spoke with the service managers, head of nursing, the senior charge nurse, the lead nurse, consultant psychiatrist and pharmacist.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

We were told that the recent increase from 21 to 29 beds had been unexpected and while staff appreciated the need for patients to have access to adult acute in-patient provision, there had not been an increase in nursing capacity to meet the needs of the increased patient population.

We were aware that Ravenscraig was the only ward on this hospital site, therefore we were concerned about how the clinical team, particularly nursing staff, were able to accommodate an increase in the number of patients. We were told that with an increase in bed numbers, there had also been an increase in the acuity of mental health issues of patients. Staff were unsure at that time whether this was attributable to social isolation, the reduction or cessation of community support services or people being unable to access their usual support networks. We heard that while some services had increased their efforts to re-engage with individuals, others had not been able to increase their capacity for providing support.

We were told on the day of the visit to Ravenscraig Ward there were several vacancies for trained staff including occupational therapy and there were several locum psychiatrists. Recruitment into registered nurse posts remained a challenge and a source of frustration for the leadership team. There was recognition that while day-to-day shifts were adequately filled with bank staff, and on occasion agency staff, this was not a long term solution for the provision of person-centred care and treatment. We will therefore be asking for regular updates from managers as they continue to address the issues of recruitment and retention of staff.

While we heard from some patients who told us that nursing staff as approachable, and keen to help and provide support, for other patients they were not entirely certain who their keyworker/ named nurse was, or their specific responsibilities to assist with their recovery. This view was also extended to medical staff whom some patients felt were not regularly available or particularly welcoming towards them.

When we reviewed the care plans, we were unable to locate reviews that targeted nursing intervention and individuals' progress. We discussed this on the day of our visit with the senior charge nurse and managers as we had hoped to see an improvement since our last visit to the ward. We were aware that in the service as a whole, care plans and reviews were being worked on and suggested using the Commission guidance on our website to help in the process. We recommended that an audit of the care plan reviews was carried out to ensure that they reflected the work being done with individuals working towards their care goals, and that reviews were consistent across all care plans.

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

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

Ravenscraig Ward had been without dedicated occupational therapy provision for a considerable period of time. While there was some input from a community occupational therapist that was valued, there was an acknowledgement that without dedicated occupational therapy, patients were missing out on an essential member of the multidisciplinary team. Once again, we were informed that recruitment for this post had been fraught with difficulties, with little progress in prospect. Specialist staff including physiotherapy, dietician and primary care provision could be requested by referral and we were informed there was no issues in relation to waiting times for input.

We were told the MDT met weekly with each consultant psychiatrist holding their own separate MDT meeting. A record of each patient's care that was discussed was recorded in their electronic file. The information from the ward round was variable in detail with little evidence of consistency in relation to record keeping. We discussed this on the day of the visit as we considered that detailed minutes from meetings should be kept as they formed a basis of understanding as to how a patient was improving week to week, or if recovery was not apparent, what needed to change to ensure every patient was provided with care and treatment that met their specific needs.

Recommendation 2:
Managers should ensure clinical discussion from multidisciplinary team meetings are recorded accurately and provide a detailed account of who attended, their role, actions and outcomes. Those minutes should be stored within a patient's care records and considered as part of care and treatment planning.

We were unable to find clear discharge planning information in the MDT meeting notes and spoke with staff on the day of the visit about ensuring that this was added to all versions of the meeting note.

We were told that there were several patients whose discharge from hospital was considered to be delayed. We were advised of the reasons for these delays that were due, in part to tenancies or packages of care breaking down with individuals requiring admission to hospital and losing their home. Furthermore, there were limited resources for people who required intensive support in their community and a dearth of suitable accommodation that ensured discharges from hospital-based care were sustainable.

We were pleased to hear with the addition of a discharge coordinator, communication between the ward and community services, including the local authority, has improved. While this has been welcomed by the teams involved in patient's pathway from admission to discharge planning, it had not had the desired effect of reducing the length of time of admissions, which remained a source of frustration for patients, their relatives and staff.

Care records

Patients' notes were recorded on an electronic system 'MORSE'. While we found patients' care records easy to navigate, we were concerned there had been little improvement in documenting patient's day-to-day progress. In the daily continuation notes we would have expected to see evidence of a patient's progress, contact with their keyworker or engagement in ward based therapeutic/recreational activities. Of the electronic notes we reviewed, there was little evidence of one-to-one meetings taking place between patients and nursing staff. Due to the lack of detail, it was difficult to assess whether patients were progressing during their admission and the daily record of contact with patients lacked detail and evidence of interaction with the patient. We would like to have seen details of therapeutic engagement taking place and a subjective view from patients about their progress.

Recommendation 3:
Managers should ensure daily record of contact between nursing staff and patients is meaningful and includes both a subjective and objective account of a patient's presentation.

Use of mental health and incapacity legislation

On the day of our visit to Ravenscraig Ward we reviewed the legal paperwork for patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a limited understanding of their detained status; they could not tell us about their legal status in relation to the Mental Health Act.

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) and certificates authorising treatment (T3) under the Mental Health Act were not all in place where required and did not correspond to the medication prescribed. We found that not all T3 certificates had been completed by the responsible medical officer to record non-consent; they were not available in patients' medication kardexes, nor were they up-to-date.

We brought this to the attention of managers, consultant psychiatrist, senior charge nurse and pharmacist on the day of the visit. We were concerned treatment prescribed to patients was not legally authorised and this had not been identified through a range of governance systems available to the clinical team.

Recommendation 4:
Managers should ensure that current patients on Ravenscraig Ward who require a T2 or T3 certificate have one in place, should arrange for a copy to be held with the drug kardex and should ensure all psychotropic medication is legally authorised.

Recommendation 5:
Managers should put in place a robust system to identify when a T2 or T3 certificate is required to authorise the treatment of a patient.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (AWIA) 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.

On the day of our visit, we identified section 47 certificates dates that had expired. We would consider medical treatment delivered to those patients with expired section 47 certificates as unauthorised. We discussed this on the day of our visit with managers and medical staff and we advised that as a matter of urgency, an audit of all Mental Health Act and AWIA paperwork to ensure certificates required to authorise treatment were put in place.

Recommendation 6:
Managers should ensure medical staff undertake regular audits of section 47 certificates and accompanying treatment plans.

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. Where a patient had nominated a named person, we found copies of this in the patient's file.

Rights and restrictions

We were told that patients had access to independent advocacy who had re-commenced their weekly drop-in sessions. Ward staff, including social workers with mental health officer (MHO) status provided information about how to access legal representation and support from independent advocacy services. Leaflets and contact information was made available and private access to telephones was encouraged, in order for patients to seek representation during their admission to hospital.

Ravenscraig continued to operate a locked door, commensurate with the level of risk identified with the patient group. The ward was accessed through a secure door entry system. Patients and visitors could enter or leave the ward by asking a member of the ward team.

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

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 s274 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. On the day of the visit, we could not locate advance statements in patient's care records. While patients may not be keen to write an advance statement during their admission to hospital, they should be provided with information and guidance in relation to making an advance statement and where to seek support to do this.

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 heard from patients that they value the interactions they have with staff either on a one-to-one basis, or in small groups. Without a dedicated occupational therapist to engage with patients both in relation to therapeutic individualised engagements and group work, there was a sense patients were not provided with opportunities that could further improve their recovery.

We were disappointed with the lack of progress with having a detailed, imaginative programme of activities. We recognise this is an important part of patients' recovery and offers opportunities to learn new skills, socialise with peers and for staff it is an opportunity to provide therapeutic engagement.

Recommendation 7:
Managers should consider opportunities to provide an activities co-ordinator from their staff establishment.

The physical environment

On the day of the visit there were 22 patients in the ward, however with capacity for up to 29 patients, we were told this number could and often did fluctuate from week to week. With an increase in bed numbers, dormitories looked cramped with no additional storage space for patients' belongings. Each dormitory had a shared bathroom with showering facility. The bathrooms for each of the four dormitories were dated and, as a result of that, did not appear hygienic. We were keen to see the single bedrooms as during our last visit we considered them to be unwelcoming, sparsely furnished and required to be re-decorated. We were disappointed to see none of the single rooms had been updated and remained in a very poor condition.

We were concerned about the controlled access to hot and cold beverages for patients. We were told patients no longer had access to the trolley in the sitting room that had tea, coffee and cold drinks. The kitchen was also closed, therefore patients had to ask staff to make drinks for them. We were told access to the kitchen and trolley had to stop due an identified and ongoing risk. We discussed that this was an issue for patients, highlighting patients had the right to access to foods and fluids when required and they should not have that right restricted. As a matter of urgency, we asked senior staff to ensure they devise a plan to accommodate all patients to ensure their health and well-being is not compromised.

We were pleased to see the ward's reception area has had significant improvements and this included the room available for visitors. There had been funding for new sitting room furniture and this had made a difference to the communal area. The dining room was still located away from the main ward and was not able to accommodate the increase in patient numbers. Patients could also have their meals in the communal sitting rooms or in their bedrooms.

During our last visit we noted that patients were permitted to smoke in the ward's garden; this was still the case. Furthermore, we were able to smell smoke in the ward, which seemed to come from the garden area and the smell permeated the dormitory next to the fire door that allowed access to the garden. We drew attention to the situation again. Senior staff spoke of their own frustrations as it remained difficult to support patients to stop smoking, even temporarily, using nicotine replacement therapy or with help from smoking cessation staff.

Recommendation 8:
Managers should address the environment issues in relation to updating fixtures, fittings and decoration. A programme of scheduled works with an identified timescale for each section is required as part of the service agreement from 2021.

Recommendation 9:
Managers should ensure all patients have access to food and fluids and where restrictions are deemed necessary, alternative options are available for patients.

Any other comments

The care team in Ravenscraig Ward have had to face several challenges out with their control, however they have remained stoic in their attempts to engage with their patients, knowing relationships built on trust and empathy are the cornerstone of compassionate care. With ongoing difficulties in recruiting new staff and limited opportunities to work with an occupational therapist, the ward-based team seem unreservedly committed to supporting their patients even without a full MDT in place. We saw interactions between nursing staff and their patients that were caring, staff appeared calm and keen to genuinely engage with each patient. It was clear senior nursing staff had a vision for the care and treatment that want to be able to provide and were hopeful this would be possible with the right resources in place.

Summary of recommendations

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Recommendation 2:
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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.

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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