Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 27 July 2023

Where we visited

Hollyview Ward is an eight-bedded intensive psychiatric care unit (IPCU) based in the grounds of Stratheden Hospital. An IPCU provides intensive treatment and interventions to patients who present with an increased clinical risk and require a higher level of observation, and is a locked ward. This IPCU covers the whole of the Fife area, and we were informed that there was a locum consultant psychiatrist for this unit and a consultant psychiatrist for the community service. We were told the locum consultant psychiatrist would be leaving this post soon, however, a new permanent consultant would be in post in the autumn. The clinical team appreciated that this would enable patients to have a more consistent approach to their care and treatment, rather than the uncertainty, which can be associated with locum doctors.

We last visited this service on 25 July 2022 and made recommendations in relation to authorising treatment for prescribed psychotropic medication. We also made a recommendation for the service to consider how they could promote the use of advance statements. We considered at the time of our last visit that nursing staff could benefit from additional knowledge, to help support patients to discuss and document which treatments they would prefer in the future. We were provided with a detailed action plan that focussed on both recommendations and were pleased to find the issues we had raised previously had been addressed.

Who we met with

We met with, and reviewed the care of seven patients. We reviewed their care files and had the opportunity to meet with the clinical team to discuss individual patient's care, treatment, and progress.

We spoke with the service manager, the senior charge nurse, the charge nurse, the lead nurse and consultant psychiatrist.

Commission visitors

Anne Buchanan, nursing officer

Dr Arun Chopra, medical director

Gordon McNelis, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

On the day of our visit, patients were keen to tell us of their experiences during their admission to Hollyview Ward. Patients told us they felt safe and welcomed on to the ward. We heard positive comments including, "staff help me any time, especially when things are difficult for me." Another patient told us they felt like they had "won the lottery and the ward had great facilities", and we heard "my physical health has definitely improved, I feel so much better." While patients accepted that Hollyview was a ward that required more restrictions due to safety and risk, patients told us they were given many opportunities to consider their physical wellbeing and encouraged to think about fitness, their strengths, and goals for future recovery. We were told that the nursing team were available and approachable however, we heard a consistent theme in relation to how an increase in the number of nursing staff would add to the patient's experience during their stay in Hollyview Ward.

Care, treatment, support, and participation

When we last visited the service, we found examples of detailed and person-centred care plans that 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, were part of a governance programme. This ensured documentation held in a patient's care record was of a good standard and allowed the ward-based leadership team to support nursing staff in their endeavours to work with patients collaboratively.

We were also pleased to hear patients were actively encouraged to participate in all aspects of their admission. This not only included information gathered from their initial assessment; it also extended to devising care plans, shared goals between the team and patients, and regular reviews. We were able to see evidence of staff and patients working alongside each other to ensure a patient's recovery was a meaningful journey. Furthermore, strategies to help maintain recovery were communicated to other services, who would be supporting patients after their discharge from Hollyview Ward.

Multidisciplinary team (MDT)

We were told there were a number of vacancies for nursing staff, psychology staff, and for a ward-based occupational therapist (OT); the ward was dependent upon an OT from another area. While their input was valued, the ward team recognised the benefits in having their own dedicated full-time OT, not only to undertake a variety of assessments, but also to help support nursing staff, and to work with patients who required input in relation to activity and occupation. Whilst we could see evidence of a ward-based team that were committed to providing a range of activities and therapeutic engagement to aid recovery, we were disappointed that a full multidisciplinary team was not available. We would expect an IPCU to have a range of disciplines to support patients, however, at the time of the visit to Hollyview, this was not the case. Without opportunities of engagement from allied health professionals including psychology and occupational therapy, patients could miss out on fundamental aspects of a psychological and occupational approach to care and treatment. We were told recruiting not only in to nursing posts but to those of allied health professionals has remained a significant challenge. This was a continued source of frustration for the ward-based and leadership teams. Equally, patients we spoke to were aware the ward was not functioning as

well as it could if it had a full workforce established, and this was highlighted to us during our meetings with individuals.

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 was considered essential. For patients who required input from other allied health professionals, referrals could be made to physiotherapy, speech and language therapy, dietetics, and psychology. Patients admitted to Hollyview Ward usually required 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 continued throughout the duration of their admission. Staff were invited to (virtually) attend weekly meetings to hear of their patient's progress and estimated dates for transfer of care back to their host ward.

While we heard there were limitations to some aspects of patients' treatment due to staffing shortfalls, we also observed a nursing team that were clearly committed to an ethos that promoted person-centred care. Patients spoke positively about their care and treatment, were knowledgeable about their care plans and the interventions required to support their recovery.

Care records

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

Use of mental health and incapacity legislation

On the day of our visit, all eight patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with had a good understanding of their detained status.

All documentation relating to the Mental Health Act was in good order and easy to locate in the patient's electronic care records.

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 in place where required, and corresponded to the medication being prescribed. We found that all T3 certificates that had been completed by the responsible medical officer to record non-consent; they were available and up to date.

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

The design of Hollyview IPCU meets the national standards for intensive care locked wards supporting people with risks requiring a low level of security. 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 were recorded and we were able to locate all relevant paperwork in each patient's electronic care records.

On the day of our visit, there was one patient who required continuous intervention from nursing staff. This level of input should ensure patients who require it are provided with opportunities to participate in therapeutic engagement that includes one-to-one engagement with staff, or they are encouraged to undertake social activities with support. We were pleased to see evidence of daily reviews, as it has been recognised that enhanced levels of intervention by staff can feel intrusive; it is therefore essential that patients do not have this in place for longer than is necessary.

When we reviewed 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. Health boards have a responsibility for promoting advance statements.

We were pleased to see the ward had taken a positive approach to supporting patients to consider advance statements. This was also extended to the ward-based team encouraging patients to access information in relation to their detention status, advocacy services, medication, and physical and mental well-being. The Commission's publication, *Rights in Mind* was available, and there were an extensive range of QR codes for patients to download and keep as reference for many topics, which had been seen as a welcome addition for patients and staff.

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

The Commission recognises the importance of therapeutic and recreational activities, and we were pleased to hear from patients that they valued the interactions they had with staff, either one-to-one, or in small groups. However, having a dedicated member of the team who could invest their time into activities with patients had yet to happen. Activities were being undertaken by ward-based nursing staff and, with competing demands, they were unable to

increase this provision to support patients with a bespoke activity timetable. Furthermore, without a dedicated occupational therapist to engage with patients, both in relation to therapeutic individualised engagements and group work, and also to carry out specialist OT assessment, there was a sense that patients were perhaps missing opportunities that could enhance their admission to hospital or maintain skills to reduce the risk of further decompensation.

We were disappointed with the lack of progress with having a detailed, imaginative programme of activities provided by a coordinator for this ward. We recognised this was an important part of a patient's well-being and would offer opportunities to learn new skills, socialise with peers; for staff it would be an opportunity to provide therapeutic engagement.

Nevertheless, a garden had been identified for further development as a sensory therapy garden. With help from staff and patients, there were already plans in place to encourage planting and furniture design to ensure everyone using the garden could experience an environment that promoted well-being. Patients had access to a ward-based gym and for those patients who preferred art and creative pastimes, those were available too. In the ward, other recreational equipment was also available including table tennis and badminton.

Recommendation 1:
Managers should review activity provision for Hollyview Ward to ensure patients are provided with regular therapeutic and recreational activities.

The physical environment

The ward was bright, large and spacious. The facilities were modern and with access to two outdoor areas, this allowed 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 acoustic softening to reduce noise and echo, and as there were some patients with sensory issues or who experience overstimulation, we were concerned the environment may contribute to patients' inability to emotionally or physically regulate. We were pleased to hear that there was 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 should review activity provision for Hollyview Ward to ensure patients are provided with regular therapeutic and recreational activities.

Any other comments

We recognised the challenges that staff continued to experience due to important core members of the multidisciplinary team not being available to support patients. With recruitment into these posts being difficult and a situation that was unlikely to be resolved in the immediate future, we understand new initiatives to enhance patient care and treatment could be limited. However, we wish to commend Hollyview Ward for their continuing enthusiasm and determination to promote patient centred care. This was evident from the conversations we had with patients and staff, and from reviewing the care records. Nursing staff clearly wished to continue with the momentum they had established to ensure that even with limited resources, patients had a positive experience and recovery was possible, even during difficult and challenging times.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication 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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