Mental Welfare Commission for Scotland

Report on announced visit to:

Ravenscraig Ward, Whyteman's Brae Hospital, Kirkcaldy, Fife, KY1 2ND

Date of visit: 18 January 2024

Where we visited

Ravenscraig Ward is a 29-bedded, mixed-sex, adult acute admission unit in Kirkcaldy, Fife. The ward is based on the site of Whyteman's Brae Hospital, and is the only inpatient service on this hospital site; it covers the catchment area of central Fife. We were informed that, as part of a longer-term plan for mental health inpatient services across Fife, there will be a review of all accommodation and consideration is being given as to whether Ravenscraig Ward will remain in its current location.

We last visited this service in January 2023 and made recommendations relating to person-centred care planning, recording of multidisciplinary team meetings including reviews, actions and outcomes. We also made recommendations that included authorising treatment for individuals subject to Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) legislation. We extended this to individuals who required Adults with Incapacity (Scotland) Act 2000 (AWI Act) section 47 certificates; we asked for certificates to be reviewed by medical staff. We highlighted again our concerns about the ward environment and the need for funding and investment to update fixtures and fittings. Lastly, we made a recommendation in relation to activity provision that should include opportunities for recreational and therapeutic engagement.

We had received regular updates from the senior leadership team that had included several programmes for promoting quality improvement in the areas we identified as requiring attention.

Who we met with

We met with nine individuals and had the opportunity to review several care records which were held electronically. We also spoke with two relatives.

We spoke with the service manager, the senior charge nurses, charge nurses, the lead nurse, interim clinical director, clinical lead consultant psychiatrist, and advocacy services.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We met with several individuals on the day of the visit to Ravenscraig Ward. While some people had felt involved in their treatment and their views actively sought, this was not a shared experience with everyone that we spoke with. Individuals told us that the ward often felt very busy and while nursing staff made efforts to engage with individuals, this was not always possible due to competing demands of a busy ward. We heard that the nursing team were helpful and for several individuals, they had felt their recovery had been positively influenced by the care they had received. Individuals told us that sleeping in shared dormitory style accommodation was an issue; having little privacy or space for safe storage of their belongings often added to their feelings of anxiety and stress. We also heard that staff were approachable however, there was a recognition while staff were keen to provide person-centred care and treatment, it was not always possible due to current resources.

We also had the opportunity to hear the views of relatives. They reported that communication was an issue and that their views were often not sought. This was of particular concern in their attempts to engage with medical staff and was a source of ongoing frustration. We brought this to the attention of the leadership team on the day of the visit.

Care, treatment, support and participation

When we last visited Ravenscraig Ward, individuals were unable to give us examples of how they were encouraged to participate in their care and treatment. We would consider that assessments, including those for establishing risks, care planning, and discharge planning would be a shared experience between an individual and their care team. We heard from some people who viewed nursing staff as approachable, keen to help, and provide support. For other people, they were not entirely certain who their keyworker/named nurse was, or what their specific responsibilities were when assisting them with their recovery. This view was also extended to medical staff; some individuals felt they were not regularly available or particularly welcoming towards them.

For some individuals they were able to provide instances of their involvement in their care planning for example, goal setting and interventions to promote recovery. However, this was not consistent, and we discussed this concern with the senior leadership on the day of our visit. We noted that interactions between staff and individuals were warm, caring, and compassionate. Staff knew the people in their care well, and spoke of their desire to continue to improve the individual's care experience.

We are aware that Fife Health and Social Care Partnership (HSCP) inpatient services are reviewing their care planning process and documentation. We would have liked to have seen progress in this area as we had drawn attention to person-centred care planning on several occasions previously. During our meetings with individuals, we enquired whether decisions in relation to treatment options were discussed with them. Again, some individuals stated this was their experience and they valued this practice. However, this experience was not shared by everyone we met with. We recognised that participation and supporting individuals to engage with care planning should be a shared experience and we would have expected that the clinical team should be able to evidence their efforts with this. Moreover, actions and interventions which are part of a care plan need to be clear and attainable.

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 ensure care plans are person-centred and reflect the views of individuals who are receiving care and treatment.

Multidisciplinary team (MDT)

We were told the MDT met weekly, with each consultant psychiatrist holding their own separate MDT meeting. A record of each individual whose care was discussed, was then recorded in the electronic file. The information 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 consider meeting records should be detailed, as they form a basis of understanding how an individual is improving from week to week. Where actions had been assigned to specific members of the MDT, it would have been helpful to see where progress had been achieved. We saw evidence of statements that included "ongoing" in relation to actions that had been assigned, often with little evidence of any progress. We would have expected a degree of assertiveness if actions were carried over indefinitely.

When individuals had been given opportunities to attend the weekly MDT meeting, they were very enthusiastic about this. They had felt involved in their treatment and their views had been actively sought, which had supported them to feel valued and involved.

Care records

Individuals' notes were recorded on an electronic system 'MORSE'. While we found individuals' care records easy to navigate, we were concerned there had been little improvement in documenting their day-to-day progress. In the continuation notes, the level of detail was variable. There were several that offered the reader a clear indication of an individual's progress through their admission to hospital, however this was not consistent with descriptions of an individual's day-to-day activity, which could be considered as perfunctory. For example, we noted that statements including "settled", "low profile" and "no complaints offered" were regularly used in the care records to define an individual's daily presentation; we did not find those statements helpful. In daily continuation notes we would expect to see evidence of an individual'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. We would like to have seen details of therapeutic engagement taking place and a subjective view from individuals about their progress.

Recommendation 2:
Managers should ensure daily record of contact between nursing staff and individuals is meaningful and includes both a subject and objective account of an individual's presentation.

Use of mental health and incapacity legislation

On the day of our visit, 13 individuals were detained under the Mental Health Act. Individuals we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act.

All documentation relating to the Mental Health Act and the AWI Act, including section 47 certificates, were in place and accessible on the MORSE electronic record system.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We reviewed all consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found that not all treatment certificates were in place and some that were in place did not correspond with the medication being prescribed. This means that in some cases, psychotropic medication was being administered without legal authority.

Recommendation 3:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and regular audits should be undertaken to ensure the correct legal authorisation is in place.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; they are called a named person. Where an individual had nominated a named person, we found copies of this in the individual's file.

Rights and restrictions

Ravenscraig Ward 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. Individuals and visitors could enter or leave the ward by asking a member of staff.

We were told individuals had access to independent advocacy who continued to provide their weekly drop-in sessions. Advocacy staff told us the ward-based team have always promoted advocacy services to individuals who were admitted to Ravenscraig Ward. 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 for individuals to seek representation during their admission to hospital.

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 specified person restrictions were in place under the Mental Health Act, we found reasoned opinions noted in the records, which explained the need for the restrictions. Where an individual was a specified person 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 individuals' files, we look for copies of advance statements. The term advance statement refers to written statements made under sections 274 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.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment.

Activity and occupation

Individuals told us how much they valued the recreational and therapeutic activities provided by staff, and in particular by one member of the team who had taken on the role of activities coordinator recently. Individuals enjoyed the opportunities for one-to-one engagement and small group work. Several individuals told us the days spent on the ward could feel very long therefore having an activities schedule or timetable would be welcome.

We were also informed that occupational therapy provision remained problematic and that recruiting to allied health professional posts continued to be a challenge. We were told that should individuals require assessment from allied health professionals, for example, occupational therapy, speech and language therapy, or dieticians, those referrals were accepted, and input would be provided. We had also been informed Fife HSCP have agreed to invest in activity provision across all of their mental health inpatient sites. This was welcome news, and we look forward to meeting the new activity coordinators during our future visits.

The physical environment

On the day of the visit there were 26 patients in the ward; we were told this number could, and often did fluctuate from week to week. The accommodation included dormitories and single bedrooms. There are several shared sitting rooms, a kitchen (not accessible for individuals admitted to the ward) and a dining room which is located away from the main ward.

The dormitory style accommodation looked rather cramped with no additional storage space for individuals' belongings. Each dormitory had a shared bathroom with showering facility. Individuals told us they did not like sleeping in dormitories, and that sleep could be a challenge along with a lack of privacy which had the tendency to increase levels of stress and anxiety. The ward had a small number of single bedrooms. During our last visit we found them to be unwelcoming, sparsely furnished and they required re-decoration.

We were disappointed to see none of the single rooms had been updated and remained in a very poor condition. The ward environment looked dated; we would have expected a space that would be considered therapeutic to be more welcoming. Unfortunately, we did not consider Ravenscraig Ward to be a conducive, therapeutic environment. While we accept individuals who require inpatient care should have access to this service, those individuals should benefit from an environment that is fit for purpose. Once again, we found the ward that did not meet the standards of a modern-day inpatient setting.

Recommendation 4:
Managers should prioritise decisions in relation to reviewing current inpatient service provision due to the current facilities not being fit for purpose.

Any other comments

We recognised the ward-based team had many competing demands placed upon them however, we saw a team who were striving to deliver person-centred care with limited resources and in an environment that compromised their efforts. We would welcome regular updates in relation to the environment as we recognised individuals, their relatives, and staff remain optimistic that any improvements would have a positive impact on everyone.

Summary of recommendations

Recommendation 1:
Managers should ensure care plans are person-centred and reflect the views of individuals who are receiving care and treatment.

Recommendation 2:
Managers should ensure daily record of contact between nursing staff and individuals is meaningful and includes both a subject and objective account of an individual's presentation.

Recommendation 3:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and regular audits should be undertaken to ensure the correct legal authorisation is in place.

Recommendation 4:
Managers should prioritise decisions in relation to reviewing current inpatient service provision due to the current facilities not being fit for purpose.

Service response to recommendations

The Commission requires a response to these recommendations 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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