



Mental Welfare Commission for Scotland

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

Date of visit: 12 February 2019

Where we visited

Ravenscraig ward is a 30-bedded adult acute admission unit in Kirkcaldy, Fife. It is a mixed-sex ward and covers the Central Fife area. The ward has five psychiatrists who cover all aspects of care and treatment. We last visited this service on an announced basis on 14 December 2017, and made recommendations in relation to the dissemination of care plan audits, the continued monitoring of safety concerns following a risk assessment, and the physical environment of the ward. We received a response and follow up action plan to these recommendations in May 2018.

On the day of this visit, we arrived on an unannounced basis and wanted to follow up on the above issues in particular, and to look at the overall standards of care and treatment. We were also keen to speak to individual patients.

Who we met with

We met with and/or reviewed the care and treatment of six patients on the day, but unfortunately, given the unannounced nature of the visit, we were not able to interview any relatives or carers. The ward was nearly full, with 27 beds being occupied. One single room was also out of operation due to refurbishment work taking place.

We spoke with the senior charge nurse (SCN), other members of the nursing team, and briefly to one of the consultant psychiatrists covering the ward. We were also aware of a number of other professionals and visitors to the ward. The overall impression was that it was a busy ward, with several people coming and going.

The SCN advised us that the ward was always at full capacity and that there was a high turnover of patients. In addition, there were a number of nursing vacancies, which meant that existing staff could be very busy. We are aware that the issue of recruitment and retention of staff is an ongoing one for mental health services in NHS Fife, and there are plans underway to address this.

Commission visitors

Paula John, Social Work Officer

Susan Tait, Nursing Officer

Alison Thomson, Executive Director (Nursing)

What people told us and what we found

Care, treatment, support and participation

We spoke to six patients, and most stated that their care and treatment was of a good standard. Some, however, were unhappy in relation to certain aspects of care, such as time spent off the ward and taking medication. We were able to offer advice in these areas, but primarily they were issues for the clinical team. Advocacy services are in

place to assist in raising any concerns, and we noted the presence of an advocacy worker on the ward during our visit.

Patients also stated that staff were approachable and able to make time for them if they needed to discuss any aspects of their care. They added, however, that staff could be noticeably busy, and this did at times impact one-to-one engagement.

Some patients stated that they saw their doctor regularly, but they did not always feel that they were listened to. In addition, there were comments from some that they had had several changes of doctors over the preceding months. We are aware from discussions with managers that locum psychiatrists have featured heavily in the past few months. This is due to change with a series of full-time appointments to consultant posts.

The patient group on Ravenscraig Ward continues to be diverse, and includes individuals with a range of mental health issues and associated levels of risk. We were advised by staff that there were no patients currently inappropriately placed in the ward, and no patients placed in different NHS facilities outwith NHS Fife.

As highlighted earlier in the report, there are five consultant psychiatrists covering the ward, who maintain both inpatient and outpatient caseloads. They all hold weekly multi-disciplinary meetings (MDT). This can add to the workload of the nursing team, but the SCN advised that this is something that they are able to manage. There was evidence of MDT recording, but not all records contained the SCAMPER review document which was being piloted during our last visit.

When we last visited the ward, we found that there was no dedicated occupational therapy (OT) or psychology input to the ward. This remains the case, but these services are available by direct referral. We are advised that work has been undertaken recently to address this position with OT services, and there was some evidence of this input in some of the case notes. Psychology referral is made directly to the community-based teams.

We also reviewed the care plans, and found that there was inconsistent practice in the completion of these. Some were also not well organised, with a lack of appropriate filing. There was little information in relation to background history of patients, or a summary of their present circumstances. In relation to individual care planning, there was a lack of personalisation. These read as a routine list of statements as opposed to achievable interventions with discernible outcomes. Patient views and participation in care planning was also not well recorded.

There was good emphasis on physical health, but there are a high number of physical health care tools on the plans which were routine for all patients. In some instances these did not appear to be as crucial as other aspects of care planning.

In relation to risk assessment and risk management, the standard "Working with Risk" document is being used across NHS Fife mental health services.

Again, there was some inconsistency in completion of this document. Some were not as completed as fully as others, and were not signed or dated. Where there was limited detail, it was difficult to determine how this document would inform the care plan. Although many contained initial assessments, there was no evidence of review in some and they did not translate into risk management plans.

We did observe nursing staff interacting and engaging well with patients, and in discussion with them they appeared knowledgeable about patient needs and strengths.

Recommendation 1:

Managers should ensure that care plans are regularly audited, consistently completed, person centred, and regularly reviewed. Risk assessments also require individual audit.

Use of mental health and incapacity legislation

The ward had a number of patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), and we were able to locate appropriate paperwork within the case notes. The “Mental Health Act Best Practice” document was also in place, which identified periods of compulsion and issues such as advance statements or named persons. They highlighted if discussion had taken place with patients. There was also evidence of advocacy services. There was one issue identified in relation to Mental Health Act paperwork, and this was addressed on the day after our visit.

We reviewed aspects of medication authorisation, and did not find any irregularities in the paperwork.

Activity and occupation

Activities and meaningful occupation for patients continues to be a work in progress for the ward, although there have been improvements since our last visit. Despite this, patients advised us that there can still be little to do throughout the week. Early evenings and weekends are also an issue. There is no full-time activity co-ordinator on the ward, but discussions with managers indicate that this is being looked at. The majority of activity-based interventions are done by the nursing team, and at times staff can be stretched to find time for these with competing demands.

There is an activity planner in place detailing activities for each day, and the gym, which is based in a different part of the hospital building, can be accessed.

The physical environment

The physical environment of Ravenscraig Ward remains a challenge, as the space appears cramped and limited in places. Staff commented that it can be difficult to observe patients at times given a high number of doors and corridors, and the diversity

and high numbers of the patient group. We were advised that work to minimise potential ligature points had been completed across the ward in recent months.

The ward is entered through a reception area, which appears unwelcoming, and there is a secure door in place. General maintenance appears to be required and, despite some refurbishment work taking place two years ago, it did still appear to be faded in places and in need of decoration.

There are dormitory spaces for most patients, with a smaller number of single rooms. We noted that there was mould on the shower room ceiling. There appears to be a lack of additional meeting spaces for both professionals and family and friends visiting the ward.

The dining room remains the same as on our last visit, in that this is situated off the ward area in a different part of the building. Patients have to travel through the reception area to reach this.

The garden area was not secure and was unwelcoming, although we acknowledge that we visited in the winter months. There was a strong smell of cigarette smoke in the garden area.

There is a fire exit door at the end of the ward which we highlighted in our last report. This is not locked but alarmed, and a number of patients regularly attempt to leave through this door. This in our view remains a risk, particularly for vulnerable patients.

Recommendation 2:

Managers should address potential patient safety concerns in relation to the ward environment.

Recommendation 3:

Managers should ensure that the upgrade programme is regularly reviewed, and that attention is paid to the shower room, garden area, and communal areas.

Summary of recommendations

1. Managers should ensure that care plans are regularly audited, consistently completed, person centred, and regularly reviewed. Risk assessments also require individual audit.
2. Managers should address potential patient safety concerns in relation to the ward environment.
3. Managers should ensure that the upgrade programme is regularly reviewed, and that attention is paid to the shower room, garden area, and communal areas.

Service response to recommendations

Given that several of these recommendations were also made in our previous report, we will also send a copy of this report to the chief executive officer in NHS Fife.

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.

Alison Thomson
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 MWC 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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