Mental Welfare Commission for Scotland

Report on announced visit to:

Lomond Ward, Stratheden Hospital, Springfield, Cupar, KY15 5RR

Date of visit: 2 March 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.

We last visited this service in December 2021 and made recommendations in relation to person-centred care planning; nutritional value of meals provided by the hospital catering service; staff knowledge of the Adult Support and Protection (Scotland) Act, 2007 and their responsibilities to ensure safeguarding; in-person availability of advocacy services and time scales for repair and refurbishment work to be undertaken to ensure the ward is fit for purpose.

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 also to hear how patients and staff have managed throughout the last year, and how any residual issues or restrictions related to the pandemic were impacting on them.

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, and we were keen to see if there had been investment into the ward to make it more comfortable for patients, their visitors and staff.

Who we met with

On the day of the visit we met with, and reviewed the care of seven patients. We also spoke with the service managers, head of nursing, the senior charge nurse, consultant psychiatrist and pharmacist.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager

Tracey Ferguson, social work officer

What people told us and what we found

Care, treatment, support and participation

Lomond Ward was until recently a 21-bedded ward. Bed numbers had been reduced as part of pandemic management and staff and patients told us that having a reduced number of beds in the shared dormitories had been beneficial.

However, there had been a recent increase in bed numbers from 21 to 29 beds, with the addition of extra beds placed in the dormitories. We were told this 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 heard that the increase in bed numbers had coincided with an increase in the acuity of mental health problems of the patients who were being admitted. Staff were unsure whether this could be attributed to social isolation, reduction or cessation of community support services and people unable to access their usual support networks. This was discussed as part of the knock-on effect of the pandemic and 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 Lomond Ward there were a number of vacancies for registered staff, including occupational therapy. Recruitment into registered nursing posts remained a challenge and a source of frustration for the leadership team. There was a recognition while day to day shifts were adequately filled with bank and on occasion, agency staff this was not a long term solution for the provision of person centred care and treatment. We therefore asked for regular updates from managers as they continue to address the issues of recruitment and retention of staff.

We were advised that due to over-occupancy in older adult wards, these patients were being admitted to general adult wards that predominantly meet the needs of adults under 65 years of age. This situation had increased an already challenging threshold for nursing staff and for patients who were not accustomed to sharing their space with older adults. Nursing staff working in older adult wards are often provided with additional training and have expertise in caring for adults with dementia and age-related conditions; the general admission ward staff are not and this had further increased their levels of pressure. We were concerned patient care could be compromised and brought this to the attention of the senior leadership team on the day of the visit.

Recommendation 1:
Managers should address bed occupancy for both general adult admission wards and for older adult wards ensuring individuals admitted are provided with care suited to their age and mental health diagnosis.

When we last visited Lomond Ward, patients were unable to give us examples of how they were encouraged to participate in their care and treatment. We would consider assessments, including those for establishing risks, care planning and discharge planning would be a shared experience between a patient and their care team. We heard from some patients who viewed

nursing staff as approachable, keen to help and provide support and one individual considered their current admission to hospital had "turned their life around". For other patients, they were not 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 robust reviews which 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 from our last visit to Lomond Ward. We were told by one patient their "care plan was written about me, not with me" they described their care and treatment as something that was happening to them, rather than in collaboration. We were aware reviews were happening but these were not reflected in care records. We were aware that in the service, care plans and reviews were being worked on and suggested using the Commission guidance on our website to help in the process. We recommend that an audit of the care plan reviews be carried out, to ensure that they reflect the work being done with individuals who were working towards their care goals, and that the reviews were consistent across all care plans.

Recommendation 2:
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.

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 ward-based team largely comprised of nursing staff and consultant psychiatrists, with additional input from a pharmacist. Input from other disciplines, for example occupational therapy, physiotherapy and dietitian was done by referral. We have previously noted that recruitment into nursing posts had been a significant challenge; this was a similar situation with recruitment to allied health professionals' posts, such as occupational therapy. These vacancies have had an impact on day-to-day care and treatment, as more often shifts are covered by bank and agency nurses who do not know the patient population as well as the core team. This, we felt was reflected in the care records and feedback from patients whom we met with.

We were disappointed to hear activity provision was still not undertaken by a dedicated coordinator. We heard from patients that there was a sense of boredom with very little to do during the day or in the evenings. Patients told us they would have welcomed recreational and therapeutic engagement; they acknowledged the nursing team were often busy and felt they had little time to engage with activities that would, in part, ease the boredom they felt during their admission to Lomond Ward.

We heard there were discharge co-ordinators from in-patient services and the local authority who worked together to promote a seamless admission to discharge pathway. There were

delayed discharges, and this was largely in relation to accommodating individuals in their communities who required a significant package of care and appropriate accommodation to meet their needs. We heard finding accommodation and arranging packages of care could be challenging and with that there was a greater likelihood individuals would remain in hospital, even when considered ready for discharge. This was a source of frustration for everyone including individuals and their family members.

While we heard the role of discharge co-ordinators have been welcomed for some patients, there were others who felt their recent discharge and re-admission to the ward was on the back of poor communication between the ward-based team and the community mental health team. Referrals had not been expedited, therefore support at home had not been available post-discharge, and could possibly have contributed to the individual feeling unsupported.

Recommendation 3:
Managers should ensure referrals to community mental health services are in place and accepted prior to patients' discharge from hospital and that a transfer of care meeting has taken place.

Care records

Patients' records were held on the electronic system 'MORSE'. While we found patients' care records easy to navigate, we were concerned there had been little improvement in documenting patients' 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 4:
Managers should ensure daily record of contact between nursing staff and patients is meaningful and includes both a subject and objective account of a patient's presentation.

Use of mental health and incapacity legislation

On the day of our visit, 16 of the 29 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 during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act.

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.

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 being prescribed. We found that not all T3 certificates had been completed by the responsible medical officer to record non-consent were available in patient's medication kardexes, nor were the ones that were there 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. We informed the ward-based team, including the consultant psychiatrist and the senior leadership team that patients who did not have their treatment legally authorised would have to be notified formally in writing and advised of their right to seek legal advice. Furthermore, for patients who had nominated a named person, they would also require to be notified.

Recommendation 5:
Managers and medical staff should ensure that current patients on Lomond ward who require a T2 or T3 certificate have one in place. These certificates must correspond with all prescribed psychotropic medication, and a copy should be held with the medication kardex. A system of regular auditing compliance with this should be put in place.

Recommendation 6:
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 and compliance with such should be audited.

Rights and restrictions

We were told patients had access to independent advocacy, and this service has now 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 were made available and private access to telephones was encouraged in order for patients to seek representation during their admission to hospital.

Lomond Ward continued to operate a locked door, commensurate with the level of risk identified in the patient group. The ward was accessed through a 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 the corresponding reasoned opinions.

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

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 recognise the importance of therapeutic and recreational activities and we heard from patients that they valued the interactions they had with staff on either a one-to-one basis, or in small groups. However, having a dedicated member of the team that can invest time and energy into activities with patients had yet to happen. Furthermore, without a dedicated occupational therapist to also 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 in having a detailed, imaginative programme of activities. We recognised this was an important part of each patient's recovery and offered opportunities to learn new skills, socialise with peers and for staff was an opportunity to provide therapeutic engagement.

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

The physical environment

Lomond Ward offered a significantly large environment with patients' accommodation in one area and a separate space for activities, meeting rooms, a bright and welcoming visitor room and a student nurse resource room.

The ward environment was bright and inviting with recent updates to the communal areas evident. We were concerned to hear maintenance issues for the environment were still not carried out in a timely manner, and patients told us this was an issue for them.

There were a mixture of single bedrooms and shared dormitories. We heard that while some patients were happy to sleep in dormitory-style accommodation, others told us it was a source of anxiety and stress. Patients also told us they felt the dormitories lacked privacy and at times their sleep was disturbed due to other patient's activity overnight. Moreover, dormitories had increased from four to six beds, which gave a sense of the bedrooms being rather cramped with limited storage facilities.

Patients had access to outdoor space with extensive hospital grounds that provided opportunities for patients to use the outdoor exercise equipment or attend the horticulture service. There had been a new garden fence erected to provide additional safety and security. While this had been welcomed, it did appear rather intimidating with some patients describing the new fencing as "similar to a cage".

In line with public health promotion, the hospital had recently implemented a no smoking policy. Staff have encouraged and supported patients to consider either stopping smoking or reduce their tobacco intake. Patients were offered nicotine replacement therapy and supported to consider strategies to improve their physical health during their admission to hospital. Staff told us it was too early to determine whether this implementation had improved

overall health inequalities, however they were hopeful that by working together, the health of patients would improve.

Any other comments

We were told while recruitment into nursing posts remained a significant issue, however staff had been encouraged to attend training opportunities and all mandatory training had been successfully completed. This was impressive considering the competing demands each member of the team experienced. We were keen to hear about the ward's determination to improve patient care in the future, with input from the Quality Improvement Team. This had seen the re-implementation of the 'Safe Wards' programme, the Scottish Patient Safety Programme and improving knowledge and skills through NHS Education for Scotland. We were told that the senior ward-based leadership team were committed to ensuring the mental health and well-being for their team with charge nurses having commenced a well-being initiative for all staff. We wish to acknowledge patients we met observed a nursing team that were attempting to provide care which would have been more positively received, had it not have been for a consistent shortage of a core nursing team. Patients welcomed the input and engagement from staff; however, they recognised nursing staff were faced with many competing demands, which in turn compromised patient's recovery and length of their admission to hospital.

Summary of recommendations

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Recommendation 2:
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Recommendation 3:
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Recommendation 6:
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Recommendation 7:
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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 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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