Mental Welfare Commission for Scotland

Report on an unannounced visit to: Succoth Ward, Mid Argyll Community Hospital, Blarbuie Road, Lochgilphead, PA31 8JZ

Date of visit: 17-18 October 2023

Where we visited

As part of a series of visits to more rural adult acute inpatient admission wards, the Commission undertook an unannounced visit, commencing in early evening, and continuing into the morning of the following day, to better understand what activities were available, and how care and treatment was provided in settings that did not have the same access to facilities available in more urban inpatient units.

Succoth Ward is a 16-bedded adult acute admission ward located on the ground floor of Mid Argyll Community Hospital. Nine patients were receiving compulsory treatment. The ward covers the four geographical sectors of mid Argyll, Kintyre, Oban, and Dunoon; and each has their own consultant psychiatrist. On the day of our visit there were no vacant beds. We were told that the ward consistently operates with high occupancy levels and there were two people waiting to be admitted. A staff team huddle is held each morning and includes the community teams where relevant.

We last visited this service in June 2022 and made recommendations about the introduction of a system for auditing consent to treatment forms, that restrictions which were imposed should be legally authorised, and that there should be a review of the activity provision.

We received a response from the service, and we wanted to follow up on the actions taken from previous recommendations, as well as any remote and rurality issues.

Who we met with

We met with the senior charge nurse (SCN), the head of adult services, and a clinical services manager.

We reviewed the care of seven patients, five who we met with in person and two who we reviewed the care notes of, as they did not wish to meet Commission staff.

Commission visitors

Mike Diamond, social work officer

Margo Fyfe, senior manager (practitioners)

What people told us and what we found

Care planning and documentation

The SCN met with us and facilitated our familiarisation of the ward. We were informed that paper records were still in operation and kept in ring-bound folders. There is a plan to migrate to digital/computer records, with community services moving onto the same electronic platform as social work services.

We found the care plans to be underdeveloped, with little detail as to how the individual was recovering against specific detailed person-centred goals. There was little or no evaluation, and one of the people that we met with had no care plan at all. Paradoxically, the same person had two multidisciplinary team meetings (MDT) held about them but did not have any care plans in place. This requires further audit by nursing managers to follow the Commission's good practice guidance for care planning. 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

We did not see evidence of one-to-one discussions with named nurses taking place on a regular basis, and we would suggest these be highlighted in the paper files. These would provide a good source of therapeutic interaction with individuals that assist in measuring key components of any care plan. We asked about staff pressures and were advised that there were five or six qualified staff nurse vacancies at present, and that everything was being done to successfully recruit to these.

We saw that physical health care needs were being addressed and followed up appropriately. However, we noted that for people from outwith Argyll & Bute area, these were followed up by their local service and not by clinicians in the hospital. We would suggest that given they were inpatients in the hospital, this should be reviewed, and consideration given to all inpatients receiving the same service, regardless of which area they reside in. This would also reduce the need for nursing escorts out with the ward to support individuals attending their sector clinic.

When we reviewed the care plans we were unable to locate robust reviews which targeted nursing intervention and individuals' progress. We discussed this with the SCN. In some files there was no evidence of review after the initial assessment. Individuals we spoke with could not tell us about their care plans.

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the individuals' progress towards stated care goals. Care plans are required to be person-centred and measurable, including use of de-escalation techniques where needed.

We would like to have seen more evidence of staff trying to use de-escalation techniques and for these to be recorded in the nursing notes, rather than the regular use of 'as required' medication.

Multidisciplinary team (MDT) meetings did not always specify who attended, or whether the individual or relative were present. We were pleased to learn that staff were using different

computer platforms to encourage colleagues and relatives to join these meetings remotely. We would like to see more detailed information captured in the MDT minute. We found that in one MDT minute there was a record of a team member in attendance, and in a duplicate minute for the same meeting, they were not in attendance.

Recommendation 2:
MTD reviews need to consistently record attendance and progress or lack of movement in the care plan. Actions need to be monitored and tasked appropriately to staff including feedback to individuals/relatives if not in attendance (as appropriate).

Use of mental health and incapacity legislation

On the day of our visit, nine of the 16 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The people 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.

Following our previous visit, we reviewed the documentation relating to the Mental Health Act and the Adult with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. These were only required for two individuals. However, we found that one person had a T2 certificate in place for an as required medication by injection. The Commission does not consider this to be good practice; this is because it is unlikely that those individuals would be consenting to receive this treatment if it had to be administered in circumstances where restraint may be required. We advised that this should be corrected immediately. We informed staff on the day that this required the attention of the responsible medical officer, and that this had been identified as a recommendation in our last visit. We also highlighted that we had found inconsistencies on the prescription sheets, namely the full dates were missing; we found that the date and month were annotated but the year was not.

Recommendation 3:
Managers should review their system for auditing consent to treatment forms in order to rectify errors immediately, and ensure restrictions imposed were legally authorised.

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 an individual had nominated a named person, we found copies of this in their file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the AWI Act 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. We did not see any s47 certificates or identify anyone who required this.

There were no patients on a covert medication pathway.

Rights and restrictions

Succoth Ward continues to operate a locked door, commensurate with the level of risk identified with the patient group. There is an external exit door from the hospital located very close to the ward itself, and therefore it is appropriate that a coded magnetic lock is in place for the ward. This is also in place to prevent anyone wandering into the ward. The SCN advised us that informal patients are supported by staff to leave/enter the ward.

There were no enhanced observations in the ward on the days visited.

Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. As stated in our last report, 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 an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

We noted that paperwork was in place for two individuals who were deemed specified persons. However, the reasoned opinion was not clearly recorded in the care folder, although there was a note of the individuals being told. Managers should consider MDT training in the application and use of specified persons.

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 look 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 did not identify any advance statements on our visit.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that people 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

Recommendation 4:
Managers should ensure staff are cognisant of the specified persons requirements, including detailing why it is in place in the records, and that information given to individuals.

Activity and occupation

We were informed that the occupational therapy (OT) staff were on the ward regularly and provided good support for individuals to engage in group work and assessments. However, the feedback from individuals was that there were not enough activities on offer and not enough to do. Individuals indicated that staff were too busy, or the ward was too short staffed on a regular basis to allow staff to do any activities with individuals.

One of our previous recommendations was for managers to review activity provision and look at how this could be enhanced with the addition of an activity co-ordinator. The service response to our previous recommendation confirmed that a job description for an activity co-ordinator would be reconfigured. We were advised that this had been delayed and the post had not been advertised or filled but was being discussed at workforce planning. The Commission re-states the need for such a post to be established for this busy ward.

Now that pandemic restrictions have been lifted, and individuals are once again able to resume community activities, they are having to again adapt and cope with the changes in routine that this brings them. We heard that nursing staff will take individuals out to the local town centre if they need to go to the shops or bank. Staff informed us that informal patients often go into the town centre on their own, or attend badminton or swimming at the community sports facility.

Recommendation 5:
Managers should, as a matter of priority, review activity provision and look at how the provision can be enhanced with the addition of an activity co-ordinator.

The physical environment

The ward is located on the lower ground floor of the main hospital which allows access to, and use of dedicated garden areas. One of the gardens is designated for people from the ward and there is a shelter area for those who smoke. The garden is secure with high screening/fencing which is currently covered in algae. However, the area needs cleaning and maintenance to keep the grass maintained and fencing clean. It would also benefit from some seating, if it is to continue to be used for current purposes.

The ward was clean and bright on the day we visited and there was a quiet, calm atmosphere during the time we spent there. We were informed that staff require to seek permission from the owners of the building in order to place posters on the walls. This should be achieved with a local protocol so that patients can have information/work on display for their benefit.

Recommendation 6:
This garden requires to be maintained to the same standard as the others on site.

Any other comments

Remote/rural aspects

All ward admissions are based on the consultant's decisions to admit. Sometimes individuals arrive with the crisis team, as they are usually working with them in the community, however, some may be brought by the police. The ward staff do not offer support for retrieval.

In relation to admission/discharge, the community mental health team (CMHT) or crisis team are usually involved at some point. We were informed that discharge planning is always discussed at the MDT review meeting where the junior doctor will write the discharge letter to the GP, in tandem with the consultant. This process is supported by the nursing team and ward secretary.

We were advised that the least restrictive practices are always applied in Succoth Ward. Telephones are removed for charging due to potential fire risks. "There are no blanket bans

on anything". Individuals are informed and have discussions about 'as required' medication, as well as staff talking to them about coping skills and distraction techniques.

We were told the responsible medical officer (RMO) discusses with the individual and relative, the need for any restrictions having to be imposed, prior to the event. These would then be reviewed by the clinical team and RMO at the weekly ward round.

The ward covers the four sectors of Argyll and Bute. We heard that for informal patients and for patients whose detention has been suspended, they can go into the town centre for any of the activities listed earlier (shops, swimming, badminton, etc).

Staff informed us that they try and involve relatives and carers where it is appropriate and always do this when the patient gives their permission. This includes invites for reviews or during visiting.

There is no set time for visiting and families use the open visiting to suit themselves; iPads are used for video conferencing. Individuals have open access to Wi-Fi on the ward.

Children are supported to maintain contact with their parent if they have been admitted. They have the use of visiting rooms within and outwith the ward itself.

The SCN was able to obtain a copy of the joint agency Psychiatric Emergency Plan (PEP) for the area. We noted that it was out-of-date (May 2019) and did not reference any contingency plans, should there be road closures that can affect staff travelling to the ward as well as individuals being brought to the ward for admission. We suggested that this is something the new plan should address for clarity.

Recruitment is a significant issue for staffing the ward. Managers are actively trying to recruit staff to work locally and members of agency staff are constantly employed to maintain enough trained staff on shift. We look forward to hearing how the staffing situation has progressed when we next visit.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
MTD reviews need to consistently record attendance and progress or lack of movement in the care plan. Actions need to be monitored and tasked appropriately to staff including feedback to individuals/relatives if not in attendance (as appropriate).

Recommendation 3:
Managers should review their system for auditing consent to treatment forms in order to rectify errors immediately, and ensure restrictions imposed were legally authorised.

Recommendation 4:
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Recommendation 5:
Managers should, as a matter of priority, review activity provision and look at how provision can be enhanced with the addition of an activity co-ordinator.

Recommendation 6:
This garden requires to be maintained at the same standard as the others on site.

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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