Mental Welfare Commission for Scotland

Report on announced visit to:
Stratheden Hospital, Hollyview Ward, IPCU, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 5 September 2024

Where we visited

Hollyview Ward is an eight-bedded intensive psychiatric care unit (IPCU) based in the grounds of Stratheden Hospital.

An IPCU is a locked ward which provides intensive treatment and interventions to individuals who present with an increased clinical risk and require a higher level of observation. Hollyview Ward accepts admissions from hospitals based in Fife, while also admitting individuals from courts and prisons. We were informed that up until recently, the ward population had remained static due to individuals waiting for transfer to rehabilitation inpatient services. Opportunities for rehabilitation for people who have been in hospital for a prolonged period had been a challenge for mental health services. However, with several successful discharges into community placements, this had opened up opportunities for individuals to move out of Hollyview Ward to commence the next phase of their recovery.

Hollyview Ward is in the unique position of having been designed to meet the needs of individuals who by virtue of their mental-ill health require a setting that provides safety, security and a bespoke therapeutic environment.

On the day of our visit, there were seven individuals receiving care and treatment on the ward with one available bed for admission.

We last visited this service in July 2023 on an announced visit and made one recommendation in relation to activity provision. We were aware the ward had been without a dedicated activity co-ordinator for a period and while the ward-based team regularly supported individuals with recreational and therapeutic activities there was a recognition this was not always possible due to increased competing demands on nursing staff. The response we received from the service was their acknowledgment that having an activity co-ordinator post would be favourable, but that there were challenges in relation to funding for those substantive posts.

Who we met with

We met with one individual and reviewed the care records of four. We also spoke with two relatives. On the day of the visit, we were aware there were several individuals receiving care who were not able to meet with Commission visitors due to the severity of their mental ill-health. We therefore had an opportunity to speak with the senior leadership team to discuss specific areas of their care and treatment and how staff were optimising opportunities for therapeutic engagement to support their recovery.

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

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

While we had limited opportunity to meet with individuals receiving care and treatment in Hollyview Ward, we were able to meet with one individual and two relatives. We were told by an individual that they felt supported by most members of the ward-based team. Efforts to involve them in their care planning was appreciated; equally, having opportunities for regular recreational and therapeutic activities was important to them. While an admission to an intensive care setting was not agreeable to them, the nursing staff had been consistently supportive and ensured family contact was maintained.

Relatives we spoke to had some concerns about their involvement and would have preferred more contact with the ward-based team and their views sought too. We discussed this concern with the team to highlight the value of having a collaborative approach with individuals and families, particularly in this type of care setting.

We also took an opportunity to speak with staff who worked in the unit. They were very enthusiastic about the ward, their role with supporting individuals who required a higher level of support and valued the ethos of the ward, that promoted a person-centred model of care.

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 an individual'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 people collaboratively. We heard that individuals 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 individuals, and regular reviews.

With continued evidence through all care records we reviewed, it was clear the ward-based team were keen to ensure individuals were not assessed only in terms of what they were unable to do, but there was a focus on their strengths. This strengths-based model provided evidence of staff and individuals working alongside each other to ensure their recovery was a meaningful journey.

Furthermore, strategies to help maintain recovery were communicated to other services who would be supporting people after their discharge from Hollyview Ward.

Care records
Information on individuals' care and treatment was held in the electronic record system, MORSE; we found individuals' records easy to navigate.

There was a clear focus upon individual's mental and physical well-being, with a number of physical health assessments completed. People 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. Risk assessments were reviewed regularly and updated as necessary.

When we reviewed care plans, we found those to be person-centred with evidence of when an individual had participated in discussions, their specific goals to aid recovery and interventions which had been helpful. We found most care plan reviews to be detailed, and any amendments required were included in those reviews. However, there were several reviews that had been undertaken with a view from staff of "no change" or "ongoing" in relation to interventions. We would advise that if an intervention had not affected an improvement either subjectively or objectively, there may be an opportunity to consider a different intervention. Again, this would be explored with staff and the individual to ensure that an agreement was reached.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)
We were told there continued to be vacant posts for psychology staff, and for a ward-based occupational therapist (OT), meaning that the ward was dependent upon an OT from another area. While their input was valued, the ward team recognised the benefits to 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 individuals 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 MDT was not available. We would expect an IPCU to have a range of disciplines to support individuals. 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, individuals

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

could miss out on fundamental aspects of a psychological and occupational approach to care and treatment.

We were told recruitment to nursing posts and also with allied health professionals posts remained a significant challenge for mental health, learning disability and older adults' services. This was a continued source of frustration for the ward-based and leadership teams.

Individuals admitted to Hollyview Ward could present with mental ill health and illnesses related to neurological conditions. For this reason, having input from occupational therapy was considered essential. For people who required input from other allied health professionals, referrals could be made to physiotherapy, speech and language therapy and dietetics.

For individuals who had input already in place from psychologists attached to forensic services, this engagement continued.

People admitted to Hollyview Ward usually required a higher level of support and interventions during an acute phase of their illness; and for some people their admission period could be brief. Hollyview Ward staff maintained regular contact with host wards providing updates of an individual's progress. The ward-based team also provided guidance to wards prior to transfer back to the host ward.

Where appropriate, the Hollyview Ward team could provide support and advice in relation to working with people who presented with significant mental ill-health in hospital across the mental health estate in Fife.

We have asked for updates from the leadership team in terms of recruitment into allied health professional posts and we are aware of several vacancies and the determination to having those posts recruited into.

Use of mental health and incapacity legislation

On the day of our visit all individuals were subject to either the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or Criminal Procedure (Scotland) Act,1995 (CP(S)A) legislation.

All documentation relating to the Mental Health Act and CPSA were available in the electronic files.

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 or CP(S)A

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained people, 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 all in place, although

there were two prescribed treatments that required attention from medical staff due to minor oversights; these were attended to on the day of the visit.

An individual 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 the patient's file.

Rights and restrictions

The design of Hollyview IPCU meets the national standards for intensive care locked wards that support people who have risks that require 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 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. 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 individual's electronic care records.

On the day of our visit, there was one person who required continuous intervention from nursing staff. This level of input should ensure people 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 individuals do not have this in place for longer than is necessary.

When we review care records, we looked for copies of advance statements. The term advance statement refers to written statements made under ss275 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 individuals to consider advance statements. This was also extended to the ward-based team encouraging individuals to access information in relation to their detention status, advocacy services, medication, and physical and mental well-being.

The Commission's *Rights in Mind*[2] pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

[2] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

This publication was available on the ward, and there were an extensive range of QR codes for people to download and keep as reference for many topics, which had been seen as a current approach to information sharing for individuals and staff.

Activity and occupation

We made one recommendation from our last visit to Hollyview Ward, which was in relation to having a dedicated ward-based activity coordinator. On our last visit, individuals we spoke to gave us their views about the absence of this provision, noting it as an issue. We were disappointed to hear this specific post had yet to be recruited in to. While we recognised funding available for this post along with other activity coordinator positions had not been confirmed, due to feedback from individuals, relatives and staff, we would suggest that this would be considered an essential resource. We will therefore repeat our recommendation from the last visit and have asked for an update from the senior leadership team with their commitment to recruit into activity coordinator positions.

Recommendation1:
Managers should ensure within the ward staffing establishment there is an activity coordinator who is responsible for recreational and therapeutic activity provision.

Activities were being undertaken by ward-based nursing staff although with competing demands, they were unable to increase this provision to support individuals with a bespoke activity timetable. Without a dedicated occupational therapist to engage with individuals, both in relation to therapeutic individualised engagements and group work, and also to carry out specialist OT assessment, there was a sense that individuals were perhaps missing opportunities that could enhance their admission to hospital or maintain skills to reduce the risk of further decompensation.

We do wish to commend the ward-based team in their continued efforts to engage with individuals and in small groups to promote recreational activities. There are several areas in and around the ward that offered individuals opportunities for exercise, outdoor sports, pool competitions, film evenings with light snacks.

We were told everyone in the ward had contributed to a recent bake sale which had been popular with individuals both in Hollyview ward and across the hospital site. All proceeds had been re-invested into the ward to purchase new recreational equipment with everyone having a sense of achievement with their efforts.

The physical environment

The ward was bright, large and spacious. The facilities were modern and with access to two outdoor areas, this allowed individuals with the opportunity to socialise or have space to relax away from others should they wish.

There were several communal areas, different sitting areas, a kitchen, an IT suite and fully equipped gym. We were told the purchase of new furniture had helped the ward feel modern and comfortable. Further improvements to bedrooms were to take place in the near future and, with new bespoke furniture which would add to the comfort of individuals admitted to Hollyview Ward.

Any other comments

We wish to commend the determination and effort the ward-based team continued to make in their efforts to have promote a model of care that influenced recovery for individuals receiving care and treatment in Hollyview Ward. With the addition of a substantive consultant psychiatrist and support from specialist doctors', individuals admitted to the ward had an opportunity to have their care regularly reviewed and increased treatment options were available.

We recognised that having a multidisciplinary team with a range of professionals providing input into the ward would be beneficial however, we also wished to highlight that in spite of this absence; the ward-based team were promoting a model of recovery and optimism.

Summary of recommendations

Recommendation1:
Managers should ensure within the ward staffing establishment there is an activity co-ordinator who is responsible for recreational and therapeutic activity provision.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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