Mental Welfare Commission for Scotland

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

Date of visit: 9 October 2019

Where we visited

Succoth Ward is an adult admission ward providing inpatient care and treatment for men and women. The ward has 21 beds, with 13 single en-suite rooms and two four-bed bays.

We last visited this service on 8 November 2018 when we made one recommendation about authorising medication prescribed for patients detained in the hospital under the Mental Health (Care and Treatment) (Scotland) 2003 Act ('the Mental Health Act'). We received an appropriate response from the service to this recommendation.

On the day of this visit we wanted to meet with patients, and look generally at the provision of care and treatment because it had been just under a year since our previous visit.

Who we met with

We met with and/or reviewed the care and treatment of eight patients.

We spoke with the service manager, the senior charge nurse, the nurse consultant, and with one of the consultant psychiatrists working within the service.

Commission visitors

Ian Cairns, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patient involvement and participation

This was an unannounced visit, so patients had not been asked in advance if they wanted to speak to a Commission visitor. A number of patients did speak to us on the day of the visit, and generally they were satisfied with the care and treatment provided in the ward. Some patients did not feel they needed to be in hospital, or felt that they did not agree with their psychiatrist's views, but all the patients we spoke to did feel that they had good opportunities to express their views both on an individual basis to staff, and in multidisciplinary team (MDT) meetings in the ward. We also heard from patients that they were given good information about their rights, that they had good access to advocacy support when they wanted to use this service.

As mentioned above, patients told us that they were given the chance to participate and to express their views at MDT meetings. We heard several comments from patients about how nursing staff were available to provide support when they needed this. We also reviewed files for a number of patients who we did not speak to on the day of this visit, and saw clear evidence in files of patient participation in decisions about their care and treatment. We saw for example that patients had signed their care plans, and in several files we also saw that patients had signed notes from MDT meetings.

Care planning and documentation

Care plans which were reviewed were generally of a good standard. Plans appeared to cover all identified needs, and were person-centred, with a good level of detail about actual interventions to meet identified needs. We saw detailed risk assessments in files when this was appropriate, and we also saw evidence in the files of good evaluation of the plans.

Overall, the patient files were well-organised and maintained. The one-to-one support provided by staff on the ward is clearly recorded in files. The MDT meetings which take place in the ward are also well recorded, with a well-structured template format being used. The MDT meeting records have updates from professionals, clearly record any input from patients to discussions about their care and treatment, and have clear information about any actions or plans agreed. We also saw occupational therapy assessments and care plans in place in specific files, focussing both on meaningful activities and on specific plans to work with patients on independent living skills where this had been assessed as appropriate. We were pleased to see comprehensive information about input from a range of professionals to individual patients care and treatment in the ward.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Psychology provision within the ward

Various therapeutic groups are available in the ward, and nursing staff who have completed training will provide psychological interventions. Psychological interventions include decider skills training, an approach to help patients communicate and manage emotional problems, and groups to support patients with anxiety problems or sleeping issues. However, we heard that there is still no clinical psychology input in the ward, and we reviewed several cases on this visit where lack of input from a clinical psychologist was an unmet need. We also saw on this visit that patients can be admitted to Succoth Ward who have forensic mental health needs, and who have been involved with the criminal justice system before their admission to hospital. We feel it is important for NHS Highland to address the need for clinical psychology input in the ward, and to look at how ward staff can be supported to meet the very specific needs of any patient in the ward who has previously undergone legal or court proceedings.

Recommendation 1:

Managers in NHS Highland should review how patients in Succoth Ward access clinical psychology input when this is appropriate.

Recommendation 2:

Managers should consider developing a forensic pathway which sets out how forensic mental health care needs will be met if a patient with such needs is considered for transfer into the ward.

Use of mental health and incapacity legislation

Mental Health Act paperwork was well organised in the files we reviewed. We examined the drug prescription sheets and treatment certificates which should be in place to authorise medication when a patient is detained and medication has been prescribed for two months. On our previous visit we had noted that medication was not always covered by the T2 or T3 forms which should be in place to authorise medication. NHS Highland responded to our recommendation about this issue last year by putting arrangements in place to audit the consent to treatment documentation, and on this visit there were no issues in relation to T2 or T3 forms for the authorisation of medication.

Rights and restrictions

As mentioned earlier in relation to care planning, we saw evidence in files of appropriate risk assessments in place, ensuring that patients receive care in the least restrictive way possible.

The door into the ward is locked because the ward is in a community hospital, and to make sure that people cannot wander into the ward inappropriately. However, patients did not report this to be restrictive in any way. There is good advocacy input into the ward, and patients we met on the visit confirmed that they either used advocacy support, or were aware that they could access this support. We also spoke to several patients who were detained in the ward under the Mental Health Act, and they each confirmed that they were fully aware of their rights as detained patients, and that they felt they had been given good information about their

rights. We were also pleased to hear from one patient that they had been given information about their right to make an advance statement, and that they intended to do this.

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/rights-in-mind/

Activity and occupation

A timetable of structured activity provision is prominently displayed in the ward. Ward staff have responsibility for arranging a range of activities, and the hospital chaplain continues to be heavily involved in activity provision within the ward. There is a focus on providing meaningful activities which patients can engage in, but we did hear comments from patients who felt there was a lack of varied activities in the ward, and that they tended to spend a lot of time in their rooms because they did not feel activities which were available were stimulating. One patient also told us that this issue had been raised several times in the diary meetings which take place in the ward each morning, when staff and patients will discuss the structured activities to be provided that day, and the opportunities which may be available for patients to go out of the ward with staff.

Recommendation 3:

Managers should review activity provision in the ward, and involve patients in evaluating the current programme of structured activities.

Any other comments

During the visit we heard about improvement work, and about a workforce review being undertaken in the ward. We were pleased to hear about specific work being undertaken building on the Healthcare Improvement Scotland guidance, from observation to intervention. (https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/). Argyll and Bute is participating in a steering group NHS Highland has set up, looking at observation practice, but we also heard that there is a local working group which is looking at local priorities for implementing the National Observation Practice Guidance.

Summary of recommendations

1. Managers in NHS Highland should review how patients in Succoth Ward access clinical psychology input when this is appropriate.

2. Managers should consider developing a forensic pathway which sets out how forensic mental health care needs will be met if a patient with such needs is considered for transfer into the ward.

3. Managers should review activity provision in the ward, and involve patients in evaluating the current programme of structured activities.

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.

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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