**Mental Welfare Commission for Scotland**

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

**Date of visit:** 14 September 2017

## Where we visited

On 14 September 2017 the Mental Welfare Commission (the Commission) visited Succoth Ward at Mid Argyll Community Hospital on an unannounced local visit.

Succoth Ward is an adult admission ward providing inpatient care and treatment for men and women. The ward has 21 beds and is arranged so four beds can be used as an enhanced care unit if this is required. The ward has only recently transferred from the old Argyll and Bute building to a clinical area in the new community hospital. This provides 13 single ensuite rooms, it has two four bedded bays.

We last visited this service on 12 August 2015 when we made two recommendations about care planning and recording information in files. We also visited the ward on 14 June 2016, as part of the national themed visit to all adult acute wards across Scotland. On that visit we noted that care plans for most patients were detailed and personalised, but some care plans had limited information. The main issue we identified then was that the physical environment was very poor in Succoth ward, but this issue has now been addressed with the move into the new community hospital.

## Who we met with

We met with and/or reviewed the care and treatment of six patients. We spoke with the service manager and with various members of nursing staff during the visit.

## Commission visitors

Ian Cairns, Social Work Officer and visit coordinator

Douglas Seath, Nursing Officer

## What people told us and what we found

### Care, treatment, support and participation

#### Care planning and documentation

Care plans we reviewed were appropriately detailed and person-centred, and clear risk assessments were completed, with management plans in place where necessary. Reviews also appeared to be up to date.

Multidisciplinary team meeting (MDT) meetings were well recorded. We saw clear information on file about who attended MDT meetings and about decisions taken at these meetings. Where patients chose not to attend meetings, we also saw records which indicated that they had spoken to a nurse before the meeting and that their views were shared at the meeting.

### Patient involvement and participation

Patients were generally satisfied with the care and treatment provided on the ward and with the support provided by staff, and we heard several comments which indicated that they felt they were treated with respect. One patient also told us specifically that all staff in the ward were very helpful and approachable, and that this did not only include nursing staff but also medical and domestic staff. Patients also told us that advocacy support was easily available in the ward. Care plans were signed by patients and patients confirmed that they were involved in the production of these plans. They also confirmed that they can attend MDT meetings, and staff will talk to them beforehand if they choose not to go to the meetings, and will feed back decisions after a meeting if the patient has not been in the meeting. One patient did tell us that they had attended a MDT meeting and that they would have expected all the professionals in the meeting to introduce themselves, which did not happen. The patient also told us that they raised this as an issue after the meeting and that they received an apology and were told that their comments would be taken on board. The patient was very satisfied with this response.

This was an unannounced visit, so the local advocacy services did not know the Commission would be in the ward. One of the advocacy services in the area contacted the Commission after the visit to say that they used to facilitate ward conversations with patients when the ward was in the old hospital, and that managers had found the patient feedback from these conversations helpful. We were told that these meetings have not recommenced since the ward moved to the new hospital. In the old building the ward also had a telephone which was available for patients, which provided a direct line to the independent advocacy service, and patients had found this facility helpful. This direct line is currently not available in the new ward.

**Recommendation 1:**

Managers should look at reinstating the advocacy facilitated ward conversations, and at whether a direct phone line to the local advocacy service can be installed in the new ward.

## Use of mental health and incapacity legislation

We examined drug prescription sheets and the treatment certificates which should be in place to authorise medication when a patient is detained, consent to treatment certificate (T2) and certificate authorising treatment (T3) forms. These were in place for all patients who required them. Mental Health (Care & Treatment) (Scotland) Act 2003 (MHA) paperwork was also within files as appropriate.

## Rights and restrictions

As mentioned above, we saw evidence in files of updated risk assessments in place, to ensure that patients receive care in the least restrictive way possible.

## Activity and occupation

Several patients commented positively about activities available in the ward, with one patient mentioning the daily diary meeting in the morning which will discuss the activities available that day. Patients who may need support from nursing staff to go out of the ward, for example to local shops, can also bring this up at the diary meeting.

When the ward was in the old hospital, patients had access to a gym there, but that facility is no longer available in the new hospital. It is also slightly less easy for patients to access the woodland walks which are in the grounds around the hospital, although the grounds are still available and there is a walking group which people can join.

With regard to activities, there is a mental health physiotherapist post, but this has been vacant for about a year. The previous post holder did a lot of work providing activities which would encourage patients to participate in physical exercise, and we were told that the plan is to fill this post.

## The physical environment

Succoth ward had only moved into the community hospital about two months before our visit. The new environment is much more modern and pleasant, and more single rooms are available in the ward. There is also a garden space outside which is easily accessible and provides patients with access to fresh air.

We did pick up one issue from our walk round the environment with a member of staff and from comments from a patient. The front door in the ward, which is easily observable, was locked on the day of the visit. The garden at the rear is not a secure garden. If there are identified risks in individual cases it is difficult for nursing staff to monitor and supervise patients in the garden area from inside the ward, and to be aware of any attempted absconding. It would also be easy for anyone to enter the garden area without staff being aware of this. This issue could obviously be partly addressed by looking at observation levels in individual cases. However there may be other ways of monitoring the garden area so that staff are aware when an individual patient may try to leave the garden, and when anyone who may be an unwelcome visitor is in the garden.

**Recommendation 2:**

Managers should look at how the garden area can be observed, and at whether it may be helpful and appropriate to use technology to monitor the garden.

## Summary of recommendations

1. Managers should look at reinstating the advocacy facilitated ward conversations, and at whether a direct phone line to the local advocacy service can be installed in the new ward.

2. Managers should look at how the garden area can be observed, and at whether it may be helpful and appropriate to use technology to monitor the garden.

## 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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