



**Mental Welfare Commission for Scotland**

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

**Date of visit:** 8 November 2018

## **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 14 September 2017 when we made two recommendations about access to advocacy support and about observation in the garden area. We received an appropriate response from the service about the recommendations.

On the day of this visit we wanted to look generally at the provision of care and treatment, because it had been 14 months since our previous visit.

## **Who we met with**

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

We spoke with the senior charge nurse, the service manager, and the consultant psychiatrist responsible for inpatient care and treatment. In addition we met with one of the independent advocacy workers and with the hospital chaplain, who has considerable input in the ward.

## **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**

Patients were generally satisfied with the care and treatment provided on the ward and with the support provided by staff. We did hear some negative comments from patients who were detained in the ward and felt that they should not have been admitted to hospital and that they did not need treatment in hospital. We looked further at an individual case and heard that managers were taking the patient's concerns seriously, and were reviewing what happened with this particular admission.

We heard several comments from patients about how they felt staff in the ward were approachable and helpful and responded well when patients needed to speak to them. This seemed to be reflected in the number of one-to-one contacts between patients and staff recorded in individual files. We also heard specifically from some

patients that they felt very safe in the ward, that the advocacy support was good, and that they felt involved in the preparation of care plans and in the review meetings which take place in the ward.

### **Care planning and documentation**

The reviews were well organised, with a front data sheet with relevant information which seems to be well completed. Care plans which were reviewed were variable. In some files care plans were detailed and person centred, with updated descriptions of nursing interventions and evidence of review and evaluation. In some files we felt that information about an individual patient's needs and treatment goals were conflated and were being recorded in one general care plan, when it would have been more appropriate for there to be several individual care plans relating to separate and quite specific needs.

We did note, as mentioned above, that one-to-one contact between nursing staff and patients seems to be well recorded in daily progress notes. We also saw that multi-disciplinary team (MDT) reviews continue to be well recorded, with good information about who attends these MDT meetings and about decisions taken at the meetings. We also saw evidence in the files that patients are signing care plans and are participating in MDT reviews, or that their views are recorded and shared at these meetings, confirming the comments we heard from patients themselves.

### **Treatments available within the ward**

During the visit we heard that there is a clinical psychology vacancy, which limits the psychological therapies available in the ward. However, one nurse on the ward is in the process of completing a cognitive behavioural therapy (CBT) training course and is able to provide CBT in the ward. We also heard about various therapeutic groups which are available in the ward, including groups to support patients with sleeping issues or anxiety problems, and a hearing voices support group. The local Citizens Advice Bureau had a drop-in service in the ward, where patients can receive advice about benefits or financial issues. We also heard that NHS Highland is encouraging the delivery of decider skills training, which is an approach to help patients communicate and manage emotional problems. Two nurses in the ward have completed decider skills training, and will provide support using this training to patients.

### **Use of mental health and incapacity legislation**

Mental Health (Care & Treatment) (Scotland) 2003 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 when medication has been prescribed for two months. A T2 or T3 form requires to be in place to authorise medication prescribed in these

circumstances, and in two cases all medication was not covered by the T2 or T3 form. This was discussed with the ward manager during the visit.

### **Recommendation 1:**

Managers should introduce an audit tool to monitor consent to treatment documentation to ensure that all treatment is legally authorised.

### **Rights and restrictions**

As on our previous visit, 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, but this is because the ward is in a community hospital and to make sure that people cannot wander into the ward inappropriately. The door allows patients unrestricted freedom to leave the ward, so there are no issues about patients who are not detained in the ward not being able to come and go freely. There is good advocacy input into the ward and an independent advocacy worker confirmed that the service has a good relationship with ward staff, with staff encouraging referrals for advocacy support. The local advocacy service provides a drop-in service within the ward, as well as picking up individual referrals from, or on behalf of, individual patients. Though it has not been possible to install a direct phone line to the local advocacy service, which was in place before Succoth Ward transferred to the new hospital, this is because this cannot be set up with the current telephone system in the hospital. However, the advocacy service is due to move into a new office in the community hospital, and we did hear on this visit that the service feels that ward staff welcomed input from advocacy.

### **Activity and occupation**

We heard that activity provision in the ward is generally good, and the timetable of structured activity provision is displayed in the ward.

There was previously a volunteer co-ordinator post arranging activity input from volunteers in the ward, but this post no longer exists. When Succoth Ward was in the old Argyll & Bute Hospital, before its recent move to the community hospital, patients also had access to a gym, and this facility is no longer available. However, we heard that there are plans to move some exercise equipment into the community hospital so that patients will be able to access this equipment. We heard from the chaplain about the structured activities he arranges in the ward, and the ward staff spoke positively about this input. We also heard that funding has been agreed to allow a Zumba class to be arranged, and we hope that focus on developing meaningful activities which patients can engage in will be maintained.

## **Any other comments**

During the visit we heard that a number of patients have raised issues with the advocacy service about the food provided in the ward. We understand that issues have been raised about the limited options available for people who want a vegetarian diet, and about limited healthy eating options being offered. The staff confirmed that a number of issues about the food have been raised by patients and that issues are followed up in meetings with the catering service. Where issues are raised about the food in the ward, we would ask the ward manager to make sure that those issues are raised with catering services, and that the outcome of discussions is fed back to patients.

## **Summary of recommendations**

1. Managers should introduce an audit tool to monitor consent to treatment documentation to ensure that all treatment is legally authorised.

## **Service response to recommendations**

The Commission requires a response to this recommendation 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.

**Contact details:**

**The Mental Welfare Commission for Scotland**  
**Thistle House**  
**91 Haymarket Terrace**  
**Edinburgh**  
**EH12 5HE**

telephone: 0131 313 8777

e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

