

Mental Welfare Commission for Scotland

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

Date of visit: 6 February 2019

Where we visited

Hollyview Ward is an eight-bedded unit based within the grounds of Stratheden Hospital. It is an intensive psychiatric care facility (IPCU), and is therefore a locked ward. An IPCU provides intensive treatment and interventions to patients who present with an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and secure entry.

We last visited this service on 23 January 2018, on an unannounced visit, and made two recommendations: one relating to specified person regulations, and the other to the level of activities on the ward. We received a response and action plan to these recommendations in December 2018. This visit was announced.

On the day of the visit we wanted to follow up on the previous recommendations, and look at the quality and care of treatment, rights in relation to any restrictive practices, and engagement between staff and patients. We aimed to continue our discussions around the themes identified in our last themed monitoring report in this area, *Intensive Psychiatric Care in Scotland*, published in 2015.

There were seven patients on the ward, and all were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995.

The IPCU covers the whole of Fife, and admits patients across the NHS Fife area. Staff advised that they sometimes admit patients out of health board area. There are two psychiatrists covering the ward, one of whom specialises in forensic psychiatry.

Who we met with

We met with and reviewed the care and treatment of six patients, and we were able to meet with three family members.

We spoke with the clinical services manager, lead nurse, the senior charge nurse (SCN), and other members of nursing staff including student nurses.

In addition, we met with the speciality doctor that links to the consultant psychiatrist attached to this ward. A telephone discussion was also held with the consultant psychiatrist the following day.

Commission visitors

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke to on the ward were positive about their care and treatment, and felt that the nurses were approachable and communicative. They found that they could express their views clearly and discuss problems with them. Likewise, they stated that medical cover was good and that they had regular access to a doctor when required. Patient feedback in terms of participation at ward meetings was varied, as not all felt that they were able to discuss decision making in relation to their care and treatment. Some patients also stated that they didn't feel that their views were always listened to by the medical staff.

Some patients did express that they should not be in a secure facility, and we gave advice where required.

The issue of time spent off the ward was also raised by some patients, who felt that this was not always clear and at times depended on staff availability. We noted that each patient had an observation care plan which, in line with a risk assessment, detailed their time out of the ward environment. In some of the plans we looked at there was information contradictory to what patients were telling us, and they were not up to date.

The patient mix continues to be diverse, with the majority being placed via the criminal justice system and the courts. Managers advised us that this has become an issue recently, in that a lack of movement of patients from the low secure service can sometimes result in patients having to be accommodated in Hollyview. Staff are working with social care partners so that discharge can be facilitated quickly from the low secure service. We were advised by managers that this situation has also been raised at a senior level.

Family members were likewise positive about care and treatment provided on the ward. One family member did raise a particular issue with aspects of personal care, and we raised this with both the SCN and the doctor concerned.

Since our last visit there have been changes within the occupational therapy (OT) service, and we were told that there is to be dedicated input to the ward within the next few months. OT assessments are currently available by referral, but it is now anticipated that an OT will be a regular part of the clinical team. Psychology input to the ward remains available, although again by referral. Weekly ward meetings are taking place and, when required, are attended by local mental health officers employed by local authority social work services. We were advised that advocacy services are available. There is also evidence of advocacy services visiting the ward. Despite this, however, records indicate that there are limited multi-disciplined professionals attending weekly ward meetings. On occasion they are attended only by nursing and medical staff. There are, however, a full range of issues discussed there.

We are aware that there are changes taking place to the multidisciplinary team (MDT), and will be keen to review this progress on our next visit.

Managers advised us that nursing staff shortages, both in terms of vacancies and recruitment, continue to be an issue. They have developed a workforce strategy to address this issue. Consideration is also being given to staff development and training. The Connect to Recovery training (a low impact psycho-social education resource aimed at assisting patients with symptoms and recovery) was identified on the last visit. However, the SCN advised us that this work can be compromised when staff resources are short. Managers added that the Decider model will also be circulated across all mental health sites in forthcoming months. Please see good practice section for further information.

Care plans contained good documentation and were well-organised, with information easily located. There were good examples of standard paperwork, such as the initial assessment and mental health best practice paperwork. In some instances we found completion of the care plans was inconsistent, as was care plan reviewing. Some of the care plans could be more person centred, as they had little information on individual outcomes for patients. The chronological notes, however, contained rich detail in relation to care and treatment involvement, nursing interventions and participation. The nursing one-to-one interventions in particular could be more identifiable.

MDT meetings are also documented. We noted that medical records are held separately from nursing notes, and some staff did comment that this can occasionally result in gaps in information occurring between professionals. We raised this with the SCN and consultant psychiatrist for the ward, who told us there is a system in place which records and transfers information. However, we were concerned at this lack of communication - particularly when it could relate to areas of high clinical risk with patients.

As mentioned previously, we met with a number of relatives during this visit and they told us that they were able to see their loved ones regularly and were able to use the visiting facilities. Family involvement was being promoted where appropriate.

Recommendation 1:

We would suggest that managers review how issues of clinical risk are recorded and shared across the multi-disciplinary team.

Use of mental health and incapacity legislation

Mental Health Act best practice records are on file for each patient, and we were able to find information relating to compulsory measures, restrictions, and information in relation to rights being shared with patients. As highlighted earlier, the Mental Health Act best practice form aids this process.

We were also pleased to find that the 'consent to treatment' (T2) and 'certificates authorising treatment' (T3) forms under the Mental Health Act were completed appropriately. In one case it was our opinion that a patient was not fully consenting to treatment, and therefore required a T3 form. We raised this issue with medical staff on the day and requested they review this situation.

Section 47 certificates and treatment plans under the Adults with Incapacity (Scotland) Act 2000 were in place authorising treatment for those unable to give valid consent, where required.

Rights and restrictions

Hollyview has a locked door policy in place. We were advised that there is no seclusion room, although there is a relaxation room should patients require individualised nursing and a higher level of observation. This room was in use during our visit. We discussed with staff the new guidance published in January 2019 by Healthcare Improvement Scotland, "From observation to intervention." They advised that work is ongoing within NHS Fife to implement this. The guidance can be viewed here:

<https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/>

Patients are encouraged to spend time out of their rooms between the hours of 10.00am and 4.00pm, and rooms can be locked during this time. This is to encourage participation in ward activity, but is individually care planned and it can be flexible.

Some patients were subject to specified persons regulations, for example where they were restricted in terms of access to correspondence and telephones in relation to risk. We were able to find appropriate paperwork in files, and reasoned opinions were also recorded.

We also found evidence of staff discussing advance statements and named persons, along with offering advocacy services.

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

We were informed that activities for patients have been reduced to some degree given the difficulties in staffing levels in recent months. Activities are primarily undertaken by nursing staff as there is no dedicated occupational therapy input, but this will change over forthcoming months. We did, however, find evidence of relaxation and recovery groups, access to the gym, pool, board games, arts and crafts, baking and self-catering, and newspaper groups. Despite this some patients advised us that they still felt there was a lack of things to do, and were aware of the lack of staff availability to assist with activities.

We found good recording of activities, and we will continue to note the progress of staff input to activities over subsequent visits. It was clear that patients were able to spend time out of the ward where appropriate.

The physical environment

The new environment at Hollyview Ward continues to contribute to both a positive staff and patient experience. The ward is bright, spacious, and decorated to a high standard, although in some parts it could benefit from artwork on the walls. The visiting area and attached garden is also a pleasant area for families and friends, and is away from the clinical space. We received no negative comments in this area. There is a central courtyard area which can be accessed from all parts of the ward, and this is well maintained.

There are a series of other rooms where patients can go for a quiet space. There is also a therapeutic kitchen and a computer room where patients, where appropriate, can use facilities to access information about the Mental Health Act, benefits, and other topics.

The SCN advised that the ward is part of the Safe Wards scheme. There is a notice board available with staff information, although this is not easily seen as you enter the ward.

Summary of recommendations

1. We would suggest that managers review how issues of clinical risk are recorded and shared across the multi-disciplinary team.

Good Practice

We were encouraged to see that work is being undertaken to look at the workforce strategy of the ward, both in terms of recruitment, and training and development.

This will focus on looking at team development and the provision of training for staff, to develop recovery focused and self-management approaches for patients in their care. This is at an early stage, and we will continue to discuss this on future visits.

Service response to recommendations

The Commission requires a response to its 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.

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