

**Mental Welfare Commission for Scotland**

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

**Date of visit:** 31 January 2017

## **Where we visited**

Hollyview Ward is a new eight bed facility based within the grounds of Stratheden Hospital. It replaces the former intensive psychiatric care unit (IPCU) which was housed in one of the old Victorian buildings and provided six beds in dormitory accommodation. 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 a locked door.

The development of the ward began in May 2015 with consultation with past and present patients. The facility offers a more homely environment with a new design which encompasses the main building centred around an internal courtyard. All patients have a single en-suite room and there is access to an art and music room, a group therapy room, a gym and a relaxation area. The structure of the new ward means that female patients can be separated from males.

We last visited this service in June 2015. This was a themed visit which included all IPCU provision across Scotland. The last visit was made to the old ward. There were no recommendations made and we were, in general, positive about the care and treatment being provided. However, we did give feedback on increasing activity provision and improving the detail in patient care plans.

On the day of this visit we wanted to follow up on the previous feedback, review the new facility and give patients an opportunity to discuss any issues with ourselves. In addition, we wanted to look at some of the issues identified in the themed visit monitoring report "Intensive Psychiatric Care in Scotland 2015". These included longer stays for female patients, support and discussion for patients following periods of restraint, and rights in relation to other restrictions.

On the day of our visit there were eight patients on the ward. All were detained under the Mental Health (Scotland) (Care and Treatment) Act 2003 or the Criminal Procedure (Scotland) Act 1995.

## **Who we met with**

We met with seven patients and looked at their records. We also spoke with one relative.

We spoke with the clinical services manager, the ward manager and some of the staff nurses.

## **Commission visitors**

Paula John Social Work Officer

Douglas Seath Nursing Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

The patients we spoke to were very positive about the care and treatment provided by the nursing staff and allied professionals and had no concerns to raise. Most patients stated that they found nursing staff approachable, and that they could speak to them in times of distress. They also stated that they had regular access to a doctor. One patient expressed very positive views of nurses, who were able to recognise her early signs of distress and spend time with her to calm her mood.

The patient group is diverse and includes individuals with a diagnosis of psychotic illness or depression and associated high levels of risk. One patient has a learning disability and senior managers and staff were looking at a more appropriate service for this individual. There is one part time consultant psychiatrist who covers the ward along with a junior doctor. There is no dedicated occupational therapy (OT) or psychology service to the ward; however, these are available by referral. These inputs were evident on the care plans. High dose monitoring of medication occurs where appropriate.

There is a strong emphasis on physical health care, and we saw evidence in the records of good follow up for physical issues. There is a gym on the ward and staff commented that they try to incorporate some level of exercise into each patient's care plan if possible. A fitness instructor is available who will visit the ward and provide an induction to the exercise equipment.

Care plans are person-centred and recovery-focused. We found these to be well organised and detailed in relation to mental, physical and social needs. There was a risk assessment on each care plan and comprehensive admission assessment reports which provided good background history on each patient. Personalised activity plans were also in place.

There was also a Mental Health Act best practice record for each detained patient. This detailed key information such as information sharing on rights, forthcoming court and Tribunal appearances and if an advance statement was in place. We were also able to see regular reviews of care and treatment recorded in the chronological notes and multi-disciplinary team meetings.

It was clear from discussions with staff that they knew their patients well and that the care and treatment being delivered was in line with patients' needs.

Contact with carers and family members were clearly recorded and the carer we spoke to was positive about the support he had received from staff on the ward and the care that his relative was receiving. Family involvement in the patient's life and, where appropriate, their support and treatment was clearly being promoted. There is a

separate area for visiting the ward and these rooms were comfortable, modern and private. There was evidence of toys and games for children visiting and we were advised that there is a policy in place in relation to young visitors.

Overall, we were impressed with the quality of care and treatment in the ward. Senior staff felt that the new environment had contributed to this to some degree. The environment is a clear improvement on the last building and aids the therapeutic atmosphere for both staff and patients. The ward manager was working towards a new ethos for the nursing team by delivering structured, individualised care with patients. This has led to a marked reduction in incidents of restraint on the ward. We were shown evidence of this from ward audits.

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

We were pleased to find that the 'consent to treatment (T2)' and 'certificate authorising treatment (T3)' forms under the Mental Health Act were completed appropriately. There was one instance where as required medication was not evident on a T2 form and this issue was addressed on the day.

Where required, s47 certificates and treatment plans under the Adults with Incapacity (Scotland) Act 2000 were also in place authorising treatment for people unable to consent.

A local advocacy service is available and patients appeared aware on how to access this.

Where patients were subject to specified persons regulations, i.e. where they were restricted in terms of access to correspondence and telephones in relation to risk, the appropriate paperwork was located in files and reasoned opinions were also recorded. Not all patients, however, were clear on their status or their right to appeal such decisions. We would encourage staff to ensure that this information is shared with patients, that their rights are explained, and they have an opportunity to appeal.

#### **Recommendation 1:**

The ward manager should ensure that a system is in place to ensure that patients subject to specified person's regulations are aware of their right to appeal.

### **Rights and restrictions**

Hollyview ward is a secure facility and the door is locked. There is a clear policy in place. We found that patients were aware of their status and rights in this area and we found no issues with suspension certificates, which authorise periods of time outwith the ward setting.

We were advised that the ward does not have a seclusion room nor is there a seclusion policy in place. The clinical services manager and ward manager advised us that prior to the ward opening they worked closely with staff on a programme of change, focusing on ward culture and developing the staff skills base. The ward has also worked closely with the Scottish Patient Safety Programme to assist and monitor these new developments.

Relaxation areas are now in place for patients should they require individual care and this is combined with structured activity or input where appropriate.

The ward manager advised that there have been no incidents of restraint within the last six months and incidents of physical aggression have reduced by 77%. We were able to view evidence which supported this finding.

### **Activity and occupation**

The need for more therapeutic, recreational and social activities were identified in our last visit to the IPCU. We were able to see that this has changed and there is input from the OT and nursing staff in relation to activities. A weekly planner of activities includes breakfast groups, baking sessions, art and music therapy, relaxation space and recovery themed groups. The gym room is also available. Activities are clearly recorded in the chronological notes and participation was evident.

Given the nature of the ward and the levels of distress that some patients experience we felt that there was a good level of involvement in activities.

### **The physical environment**

The new environment is a significant change for staff and patients and has been a key driver for change in practice at Hollyview. The ward now has a reception and visiting area which is separate from the clinical space. Patients and carers commented that they felt this was a good arrangement and allowed a greater degree of privacy.

The ward is bright and spacious and decorated to a high standard. It has a number of additional new rooms such as group rooms, relaxation rooms and a patients' kitchen. The ward has a design which enables part of the facility to be separated off from other parts of the ward.

The communal living space is large and attempts have been made to give this a more homely feel. The enclosed courtyard has a fixed canopy which covers in winter and shades in summer. There is access from all parts of the ward. The courtyard has an artificial surface which is flexible and avoids injury. There are garden pots and planting and staff and patients stated that they used this throughout the year.

## **Summary of recommendations**

1. The ward manager should ensure that a system is in place to ensure that patients subject to specified person's regulations are aware of their right to appeal.

## **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

Kate Fearnley

Executive Director (engagement and participation)

## **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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