



Mental Welfare Commission for Scotland

Report on announced visit to: Muirview Ward, Stratheden Hospital, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 21 August 2018

Where we visited

Muirview is an over-65 acute admission ward, based in the grounds of Stratheden Hospital, and is a new, modern facility. It provides assessment and treatment for patients with a range of mental health problems. Muirview has 24 beds in total and provides care for both men and women. The ward is designed so that it can be split into two, each comprising 12 patients, with assessment taking place on one side and longer treatment, particularly for those diagnosed with dementia, on the other. The ward covers Kirkcaldy, Levenmouth and Glenrothes catchment areas within Fife and there is a consultant psychiatrist covering each area. Although there were seven vacant beds on the day we visited, we were advised that the ward ordinarily has a 91 per cent occupancy rate. We last visited this service on 11 January 2017 and made no recommendations.

On the day of this visit we wanted to review progress since the ward has opened and also look at care planning, continuity of care and physical health care monitoring. This is because we had been made aware prior to our visit of some issues in these areas. This information was brought to us by users of services and their family members.

Who we met with

We met with and/or reviewed the care and treatment of six patients and two carers/relatives. There were 17 patients on the ward on the day of our visit.

We spoke with the clinical service manager, the lead nurse, senior charge nurse, and one of the consultant psychiatrists on the day.

In addition we met briefly with nursing staff on the ward, visiting occupational therapists, and the physiotherapist.

Commission visitors

Paula John, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We spoke to a number of patients and their families on the day and we received mixed views on care and treatment being delivered on Muirview Ward. Some patients spoke very highly of all staff and felt that their care was very good. Others were not so positive and this related to the lack of nursing staff available and the amount of time they had available to spend with patients. All patients commented that they felt staff were too busy and seemed stretched in their duties.

With regard to carers and family members, three told us that they were unhappy with care and treatment, however on further discussion the issue appears to be one of poor communication impacting on patient care. They cited issues such as poor induction to the ward both for themselves and their relative. One family were not clear on the role and function of the ward and stated that they had not been introduced to staff. They felt that this made communication difficult and that they had little in the way of regular updates on their relatives' progress. In addition, all three family members spoke of difficulty accessing a doctor and that personnel changed frequently. We raised this issue with the clinical services manager on the day, who advised us that there had been a period of time where locum psychiatrists on short-term contracts had been covering vacant posts. There was now a longer-term clinician in place, but it was recognised that for a small number of patients continuity had been affected.

Other issues raised by carers included a bathroom being dirty and unhygienic, and a lack of appropriate exercise and activities for their relatives. These issues were also raised with managers on the day and we have made recommendations in these areas.

With regard to care planning, we found that plans were clear and well organised. There were a number of standard NHS Fife documents in use, such as the 'Mental Health Act Best Practice' form and the 'Working with Risk' document which were very useful. There was also evidence of personalisation in care plans but this appeared to be inconsistent across the ward. For example, a care plan would state that anxiety management or distraction techniques would be used with a patient but did then not go on to specify these or tailor them to individual need.

We were pleased to see that care plans existed for stressed and distressed behaviours and triggers were identified. Life history work for those patients diagnosed with dementia again, was inconsistent. A 'Getting to Know Me' document was on record for each patient, but some had limited information or were not completed at all.

There did not appear to be a separate third-party or carer contact section within the care plans, and this information was contained in the chronological notes written by clinical staff.

It was clear from the notes that a multidisciplinary team approach is being adopted. We were able to locate minutes of these meetings on file and there was evidence of a range of professionals, including psychiatry, nursing, occupational therapy, social work, and physiotherapy. Psychology input is by referral only but there was little use of this within care plans. Three different ward rounds take place on the ward each week, which can place demand on nursing time.

We were advised that there were two patients whose discharge had been delayed and that work was being undertaken to address this.

We were also keen to review the physical health care of patients on the ward, as this issue has been raised with us previously. We were advised by managers that this area of care has been reviewed and an action plan put into place. Regular monitoring of this is taking place and initiatives, such as staff training in key areas and highlighting fluid and dietary intake, have been introduced. The service is currently developing a care pathway for treatment as a whole and this will also incorporate physical health care. We were told a new form is being piloted at shift change overs so that key information is not lost.

We reviewed records and noted that all relevant physical health care interventions are being closely monitored. We would want to be updated on any future developments and will continue to observe this work on future visits.

Recommendation 1:

Managers should review their induction process and communication policy with carers, with the aim of capturing relevant feedback and improving the service where appropriate.

Use of mental health and incapacity legislation

On the day of our visit there were three patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. We noted that all relevant paperwork was in place and that this could easily be located in records. The best practice document, highlighted earlier in this report, also gave clear direction on issues such as named person and advance statements.

For those patients who fell under the Adults with Incapacity (Scotland) Act 2000 we also located copies of power of attorney documents and welfare guardianship orders. The ward was also adopting use of the Commission's guardianship checklist.

Rights and restrictions

Muirview Ward has a locked door and access to and from the ward is managed by nursing staff. There is a locked door policy in place and each patient has a care plan in place which records their time off the ward. This varies for each individual patient.

There were no patients subject to restrictions and there is clear access to advocacy services within the hospital.

With regard to authorisation of medical treatment, we found no issues with the required paperwork (consent to treatment certificate (T2) and certificate authorising treatment (T3) forms).

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.mwscot.org.uk/media/369925/human_rights_in_mental_health_services.pdf

Activity and occupation

We were advised that an activities co-ordinator post is available and that this will be part of the nursing complement. The senior charge nurse told us that recent activities on the ward have included an eight-week session of a music therapist which was successful. There were also board games and art materials, however, we saw little evidence of activities taking place on the day we visited and some patients told us that there was not enough to do.

There is a gym off the ward on the hospital site and an occupational therapist has regular input. The occupational therapists keep their own recordings of Muirview Ward itself but also put entries into notes. We were made aware of one situation where a patient was not able to attend the gym as staff were not available to escort him there.

We were not able to locate an activities weekly planner on the ward.

This situation is in contrast to our last visit where activities were taking place and clearly recorded. Whilst recognising that staffing implications have had an effect, we would ask that this situation is reviewed.

Recommendation 2:

Managers should review the input of activities on Muirview Ward involving all relevant disciplines.

The physical environment

Muirview was a newly-built ward and has a large spacious environment. Entry to the ward was via a reception-type area. This includes the nursing station and a series of staff offices. There was also an interview room here. Access to the ward itself was via a locked door. All patients had single rooms with en-suite facilities. Two of these rooms had disabled facilities. The ward communal areas include a living and dining space which was open plan and limits privacy. However, this could be partitioned into two smaller rooms and a quiet seating area was available at the end of the ward.

There was also a laundry room, a kitchen area for the use of patients and visitors, and an assisted bathroom with a hoist.

Patients had access to a garden which had paved slabs on the ground, posing a risk to vulnerable patients.

Overall, on the day of our visit we found the ward to be clean and modern and a welcome improvement on the previous building. The nursing staff advised that the large space can make observation of all patients challenging at times.

Summary of recommendations

1. Managers should review their induction process and communication policy for carers, with the aim of capturing relevant feedback and improving the service where appropriate.
2. Managers should review the input of activities on Muirview Ward involving all relevant disciplines.

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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