

Mental Welfare Commission for Scotland

Report on announced visit: Ravenscraig ward, Whyteman's Brae Hospital, Whyteman's Brae, Kirkcaldy, Fife KY1 2ND

Date of visit: 14 December 2017

Where we visited

Ravenscraig ward is a 30 bedded adult acute admission unit in Kirkcaldy, Fife. It is a mixed sex ward and covers the Central Fife area. The ward has five psychiatrists covering all aspects of care and treatment. We last visited this service on 30 March 2016 when we undertook a local visit and made recommendations relating to audit of medication and activity provision.

On the day of this visit we wanted to follow up on the previous recommendations, look again at care and treatment of patients, care planning and the issues identified in our adult acute themed visit report published in April 2017. These include patient rights, length of stay, good discharge planning and an emphasis on physical health care. A copy of the report is available:

https://www.mwcscot.org.uk/media/356615/adult_acute_report.pdf

Who we met with

We met with and reviewed the care and treatment of eight patients. No carers, relatives or friends wished to speak to us on this occasion.

On the day of our visit there were 25 patients on the ward. We were told that this was unusual as occupancy is normally high, with limited vacant beds. There were two patients identified as being delayed in terms of discharge. We were told both had complex needs and that services were struggling to find appropriate supports to meet these. We reviewed both of these individuals' care plans and found that attempts were being made to resolve these issues, albeit slowly, and we will follow this up.

We spoke with the lead nurse for the service, the senior charge nurse and nursing staff on the ward. We also spoke to two psychiatrists who cover the ward, and the clinical lead for psychiatry who was able to update us on planned changes for community mental health services, and their delivery across Fife. We look forward to these changes being implemented.

Commission visitors

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

Dr Mike Warwick, Medical Officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke to were positive about their care and treatment, but the majority commented that nursing staff in particular were too busy, and appeared to be limited in numbers at times. Patients stated that this impacted on the time that was spent with them. When they did engage with nurses however, they stated that this was positive. Nurses were approachable and that they could speak to them in times of distress. Patients also commented that they had regular contact with their doctors.

The patient group is diverse and includes individuals with a diagnosis of psychotic illness or depression and associated levels of risk. One patient had a learning disability and another, a diagnosis of alcohol related brain damage. Staff had ensured that appropriate services were in place to meet their needs while on the ward.

As mentioned, there are five consultant psychiatrists that cover the ward. This results in five ward meetings a week which the SCN advised can be a challenge in terms of providing nurse cover. There is no dedicated occupational therapy (OT) or psychology service to the ward, however, these are available by referral. There was some evidence of these inputs on care plans.

The multi-disciplinary meetings (MDT) were well documented within the case notes with attendance of OT, social work and pharmacy being involved. It was clear that patients were also routinely invited to these meetings, although less evidence of family members and carers being involved.

The care plans that we looked at had some personalised information and emphasis on recovery based care, however, we found that this was inconsistent across the records we read. Review of the care plans was likewise inconsistent and difficult to identify. This was an issue that we identified in our last local visit report and we would reiterate that, although in practice this may be happening, it should be clearly highlighted within the notes.

We were advised that a short, review document (SCAMPER), which is used at the MDT meetings, is currently being piloted and both aids this process and adds to communication between staff and knowledge of patients overall.

A 'working with risk' document was part of the assessment of patients on admission on the ward and although a standardised document, it was completed in a person-centred manner and looked at both positive risk taking and potential for future risk. Again, there was inconsistency in completion and not all evidenced that review had taken place.

Physical health care was identified within the notes with the use of a 'Passport to Health' document and where patients identified a physical health problem, this was addressed promptly.

In summary, we were able to observe staff engaging well with patients and they impressed as having a good understanding of their role and needs. Staff did inform us that the ward was busy and constantly challenging. The SCN also advised that in the

last number of months, they have devised an activity programme, become part of the safe wards initiative as part of Scottish Patient Safety Programme and are looking to develop their work on patients' rights. We will be keen to see the outcomes of this work on our next local visit.

Recommendation 1:

Managers should ensure that the findings of regular audits are disseminated to staff, and changes in practice made accordingly.

Use of mental health and incapacity legislation

The ward had a number of patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) and we were able to locate appropriate paperwork on case notes. In addition, the ward uses a standard best practice guideline which ensures that patients are informed of their rights. Advocacy services are in place and it was clear that this service was being used by patients. Staff were also aware on how to access this.

The doctor within the visiting team was able to review all aspects of medication and found only one instance of authorisation of medical treatment that required attention and raised with staff. We were also pleased to find that the issue of intramuscular 'as required' medication for non-detained patients, which had been identified on our last visit, did not arise.

Rights and restrictions

As detailed above, we found that where patients were subject to restrictions under the 2003 Act, appropriate measures were in place with corresponding paperwork. We did not identify any patients who were subject to unlawful deprivation of liberty. In addition, where patients were subject to specified person's 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.

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

Activity and occupation

Following our last visit to Ravenscraig, we made a recommendation that activity provision should be reviewed, as we heard from a number of patients that there was little to do. We were pleased to find that this review has taken place and that work is still taking place in conjunction with another ward in NHS Fife as to how activities and therapeutic activity can be improved. We were provided with a weekly timetable of activities which included relaxation groups, problem solving sessions and creative writing.

We are also aware that patients can access the gym facilities within the wider hospital setting following liaison with the OT department.

We welcome these changes, although some patients advised that there are still limited options available and little to do at early evenings and weekends, and we recognise that this will require further consideration.

The physical environment

The physical environment of the building is an ongoing issue, given that the ward appears dated in relation to many others that we visit across the country. For example, the dining room is situated off the main part of the ward, so staff and patients need to travel through the reception area to access this. We did note that the reception area itself is a relatively new addition to the ward, in an endeavour to manage visitors, but it appeared sparse and unwelcoming.

However, the ward had had some upgrade in terms of new flooring, a repainting and fixed ceiling panels which had been stained during our last visit. We were advised that an additional multifunctional room is being developed at one end of the ward. When this is complete, it will offer patients an alternative room to spend time by themselves or with their visitors.

We observed that the ward contains dormitory areas, with patient spaces separated by curtains or dividers.

The ward has a garden area but this was in a poor state of repair although again, there are plans to improve this.

The staff also advised that there is a fire exit at the end of the ward that cannot be locked. But, it does mean that patients who require to remain on the ward have attempted to leave on a number of occasions. The large number of doors and entrances also means that nursing observations of high risk patients could be compromised. We were advised by the SCN that a risk assessment of the ward has taken place.

Recommendation 2:

Managers should address any potential patient safety concerns identified following the recent risk assessment carried out.

Recommendation 3:

Managers should develop a programme that identifies the continuous upgrade to the physical environment of the ward, including the stained ceiling tiles in the main areas and bedrooms, the garden area, and the rooms accessed by patients and visitors to ensure that the best can be achieved with the available space.

Summary of recommendations

1. Managers should ensure that the findings of regular audits of care plans are disseminated to staff and changes in practice made.
2. Managers should address any potential patient safety concerns identified following the recent risk assessment carried out.
3. Managers should develop a programme that identifies the continuous upgrade to the physical environment of the ward, including the stained ceiling tiles in the main areas and bedrooms, the garden area, and the rooms accessed by patients and visitors to ensure that the best can be achieved with the available space.

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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