Mental Welfare Commission for Scotland

Report on unannounced visit to:
Mid Argyll Community Hospital, Succoth Ward, Barbuie Road, Lochgilphead, PA318JZ

Date of visit: 20 November 2024

Where we visited

Succoth ward is a 16-bedded, adult acute inpatient admission ward; it is based on the ground floor of Mid Argyll Community Hospital. The ward covers the three geographical sectors of Mid Argyll, Kintyre and Islay, Oban, Lorn and Isles, and Cowal and Bute; each area has their own consultant psychiatrist.

On the day of our visit, there were 12 people on the ward and four vacant beds.

We last visited this service in October 2023 on an unannounced visit and made recommendations on several areas including care planning, the multidisciplinary team (MDT) meeting, auditing of consent to treatment documentation, activity provision and the environment.

On the day of this visit, we wanted to follow up on the earlier recommendations and gather the views of individuals in the ward at the time of our visit.

Who we met with

We met with and reviewed the care and treatment of seven people.

As this visit to Succoth ward was an unannounced visit, we did not have the opportunity to meet with relatives. We did ask the ward-based staff to inform relatives of our visit to the service, and if any of them wish to speak to us, we could contact them for an interview, to hear about their experience of the ward.

We met with the senior charge nurse (SCN), the head of adult services, and the clinical services manager.

Commission visitors

Mary Leroy, nursing officer

Mary Hattie, nursing officer

What people told us and what we found?

During our visit we were keen to hear the views of individuals receiving care and treatment and to meet with the staff who were providing input into the ward.

Individuals told us “the food, is lovely; this place is good”, “when I am not feeling well, the staff notice my nonverbal cues and they approach me and offer support”.

We were keen to know whether individuals felt part of their recovery journey, and equal partners in their care and treatment. We were informed individuals were invited and welcomed into the ward-based meetings and their views were actively sought. We saw in the MDT meetings evidence of patient participation and for some, negotiated outcomes that the individual held responsibility for. We heard from some that “I feel listened to by the nurses and doctors” and “I feel involved in my care”.

All the people we met with told us that they had regular contact with medical staff and that there was a regular review of their physical and mental health care needs. Many of the individuals did raise that there was a lack of structured activities available in the ward.

On the day of the visit, we were made aware of the ongoing concerns in relation to individuals remaining in hospital when they were considered fit for discharge. There were two individuals in the service whose discharge from the ward was delayed, which was due to identifying the respective teams that would be able to support them in the community. The multidisciplinary team (MDT) meetings and individuals’ records documented that concerns around the delays are being actively addressed by the clinical team in the health and social care partnership.

We recognise this is a national concern, with issues in finding appropriate specialist teams and services, along with challenges in securing suitable tenancies and packages of care in the community that would support an individual’s needs.

Care, treatment, support, and participation.

Care records

We heard from the team about the high level of clinical acuity. The service is for individuals who require adult acute admission but due to the lack of inpatient facilities for older adults in Argyll and Bute, this group of individuals who require a hospital admission are admitted to Succoth Ward.

The range of diagnoses and the age demographic had an impact on staff who were having to constantly adapt their nursing skills to meet the needs of the different groups. Rather than providing the specialist nursing care that is required in an adult acute admission ward, we heard that the nursing team in Succoth Ward also had to provide palliative care.

We were informed that paper records were still in operation and kept in folders. We found paper records easy to navigate and overall, the files were well organised. There was a clear focus on individual's mental and physical well-being.

On our last visit to the service, we made a recommendation about nursing care plans and that the service needed to ensure that these were person-centred and regularly reviewed to ensure they evidenced the person's journey and that care plan reviews were meaningful.

Nursing care plans are a tool that set out how care should be delivered while the individual is in the ward: best practice would be for effective care plans to be in place, to provide consistency and continuity of care and treatment. They should be regularly reviewed and provide a record of progress

On reviewing the care plans, we found variation with these. There were some exemplary, well written, person-centred care plans which did evidence good individual involvement and that some that were not. We discussed this in the team, advising that nurses could champion and lead on the further development and embedding the process of "writing person centred care plans" into practice.

We found evidence of one-to-one interventions between nursing staff and individuals and the recording of the one-to-one interventions were detailed, regular and included the views of the individual in relation to their care and treatment.

We were pleased to see improvements in the care plan review process. We found care plans that were regularly updated and in the files we reviewed, we found the reviews were thoughtful and detailed the progress and changes in the individual's care. We discussed this with the SCN, and they informed us of the work undertaken on the care plan audit process.

We reviewed risk assessments for the individuals we had met with. The risk assessments were detailed and dynamic, with regular reviews that updated when there were had been any changes to current risk; these were also routinely reviewed through the multidisciplinary team meeting.

We heard about discharges from the service and how discharge letters contained the risk assessment information along with any current plans; these were shared with both the respective GP practice and the community mental health teams.

Multidisciplinary team (MDT)
Treatment was provided in the ward in a multidisciplinary team (MDT) model of care. The ward has regular input from psychiatry, nursing, occupational therapy and pharmacy; other allied health professionals (AHPs) are available on a referral basis.

On our last visit to the service, we made a recommendation for the MDT process to document who attends the meeting, to have a clear action plan, with identified goals and outcomes and to record who carries out action. On reviewing the MDT documentation, we were pleased to find the meeting notes were detailed with information on who attended the meeting, and a clear action plan was provided, with identified goals that documented who was responsible for the respective goal/action.

We heard that MDT meeting continues to take place weekly and the meeting is attended by consultant, nursing staff, occupational therapist and pharmacist. We were told that all individuals are encouraged to attend the meeting. During our interviews with those that we met with, we were pleased to hear of their participation in the meetings.

We were advised about the plans relating to improving psychological provision in the ward. We heard of the future developments regarding low-level psychology input from a cognitive behaviour therapy (CBT) nurse. The service is at an initial stage of planning of "low intensity psychological group work". We agreed that for those who were admitted to the ward, they would benefit from psychology input and also that the wide range of input that psychology services could offer assessment and treatment options from evidence-based psychotherapies as well as psychological formulation.

The involvement of psychology services would also offer both staff supervision, support and training for the staff team. Currently, the lack of clinical psychological input is an unmet need for the service. We will ask senior managers to provide us with ongoing updates regarding this provision.

Recommendation 1:
Managers should review how patients in the ward access clinical psychology input when appropriate.

Use of mental health and incapacity legislation

On the day of our visit there were nine people detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments.

On our previous visit to the service, we made a recommendation about the need to review the consent to treatment documentation.

On reviewing the consent to treatment certificates (T2s) and the certificates authorising treatment (T3s) under the Mental Health Act, we found an error relating to one individual whose certificate did not cover all medication prescribed.

We were also concerned that for two individuals the certificates authorising treatment were out of date, with one that was overdue by a month and one by 10 days. We were reassured that a notification had been made for a designated medical practitioner (DMP) visit to be arranged.

We note this is the third consecutive visit to the service where we have found inaccuracies in the T2/T3 certificates and again repeat our previous recommendation.

Recommendation 2:
Managers must identify a robust system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given and or/restrictions imposed are legally authorised.

For those people who were subject to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) legislation, we found paperwork relating to the welfare guardianship was in place and easily located. Staff were familiar with this legal framework and understood their responsibility to ensure welfare guardians were consulted in respect of the powers granted in individuals orders.

Where an individual lacks capacity in relation to medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment follows the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. For those whose records we reviewed and who were subject to a section 47 certificate, we found these to be in place.

Rights and restrictions

Succoth Ward continues to use a locked door, commensurate with the level of risk identified with the patient group. There was an external exit door from the hospital located very close to the ward that a coded magnetic lock in place for the ward. This was needed to prevent anyone coming into the ward. On the day of our visit, we saw staff respond quickly to assist individuals who had requested to leave the ward.

There was one individual who required increased levels of observation and who was on continuous intervention. We found this restrictive intervention and the requirement for this recorded in the care plan. The SCN advised us of the review process for this restriction, and we saw evidence in the MDT notes of the continuous intervention being reviewed, discussed and recorded in the individual's care plan.

We reviewed individual restrictions and were satisfied that restrictions imposed were commensurate with the assessed risks.

The ward had access to advocacy and details of the service were on display on the notice board. Advocacy services visited the ward regularly to support individuals, and we found detailed information and correspondence in care records that noted where individuals had received to inform them of their detention status and their rights under the Mental Health Act.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. Of the files that we reviewed, we did not find any advance statements.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We recognise the value of both therapeutic and recreational activities in supporting recovery focussed care and on our last visit, we had made a recommendation regarding the need to review the lack of structured activity provision in the ward. We remain concerned about the lack of activities for individuals in Succoth Ward; it is vital that individuals receiving care and treatment have access to activities that provide stimulation.

We discussed the lack of recreational and social activities that are available on the ward, or those activities that were being offered by the nursing staff. From our review of the records, it was difficult to identify when recreational activities were offered to individuals or find evidence of any participation in activities.

There was also feedback from the individuals that we with met with, who commented that there was not enough to do. We heard that individuals spent a lot of their time in their rooms watched television, and many talked of their "boredom" in the ward.

There is a need for individuals to have access to "meaningful activities" which should include creative and leisure activities, exercise, selfcare and community access. It is a vital component.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Recommendation 3:
Managers must review activity provision and look at how provision can be enhanced with the addition of an activity co-ordinator.

The physical environment

The ward is located on the lower ground floor of the main hospital, allowing access to dedicated garden spaces. The environment was modern and there was a quiet, calm atmosphere on the ward on the day of the visit.

We did observe that many of the painted walls in shared areas and bedrooms were marked; the décor was tired and would benefit from repainting.

The ward had a small sitting area and activity spaces, two dormitories and some single ensuite bedrooms.

We were told about the 'Friends of Succoth'. This is a group that was set up to support and enhance the wellbeing of patients and staff in the ward and they raise funds and help amenities for patients and staff. We heard that recent donations had been used for gym equipment in the ward. The group have also been involved in improving the main garden area by providing new furniture and plants.

We made a recommendation on the last visit regarding the smaller garden, which was not well kept, the grass needed to be cut and there was an issue with algae on the fence. Senior staff informed us they continue to seek a solution as to how to clean the fence; this matter remains on going.

Any other comments

We discussed the challenges related to staffing in a rural setting. The team advised us that recruiting staff in the present climate has been difficult, and that they continue to use agency nurses and overtime to manage when extra staff are required. We heard that at present, there are five nursing staff vacancies in the ward, two Band 5 registered nurses and three healthcare assistants. We heard that the service has recently been able to employ four international nurses.

Summary of recommendations

Recommendation 1:
Managers should review how patients in the ward access clinical psychology input when appropriate.

Recommendation 2:
Managers must identify a robust system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given and or/restrictions imposed are legally authorised.

Recommendation 3:
Managers must review activity provision and look at how provision can be enhanced with the addition of an activity co-ordinator.

Service response to recommendations.

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland

Claire Lamza
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 Commission 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 an individual's care, treatment, and support are 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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