Mental Welfare Commission for Scotland

Report on announced visit to: Willows Ward, New Craigs Hospital, Leachkin Road, Inverness, IV3 8NP

Date of visit: 7 October 2020

Where we visited

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. From August 2020, the Commission began a phased return to our visit programme, following the recommendations in the Scottish Government's route map to recovery.

Willows Ward is an assessment and treatment unit for six adults with a learning disability.

We last visited this service on 29 April 2019 and made recommendations that patient files should contain only relevant care plans with an evaluation that indicated the effectiveness of the interventions; that specified persons forms should be audited and the delegated powers held by welfare guardians should be clearly recorded and reviewed.

On this visit we wanted to follow up on the previous recommendations and to look at staffing, the environment and activity provision, as these issues had been raised with the Commission by third parties. We also wanted to speak to patients and staff to see how they had been affected by the pandemic. We were particularly interested to hear about the impact on patient care and the effect of any additional restrictions on relatives/family, activity, and the mental health of patients.

Who we met with

We met with and/or reviewed the care and treatment of all six patients and spoke to three relatives. The interviews with patients and family members were conducted remotely in the days prior to the visits using video technology, due to restrictions placed on visitors during the pandemic. Patient interviews were supported by their advocate.

We spoke with two team leaders by telephone and email prior to the day's visit and on the day, we met with the service manager, one of the consultant psychiatrists, and other members of the nursing team.

Commission visitors

Moira Healy, Social Work Officer

Claire Lamza, Interim Executive Director (Practitioners)

What people told us and what we found

Care, treatment, support and participation

In general, the patients and relatives we spoke to were positive about the care given on the ward. We heard that there were efforts made by staff to support patients staying engaged in activities, in their own community and with independent services, during the restrictions resulting from the pandemic. We heard from staff about developments in their approaches to patient care, with regular core group meetings to review the care and treatment available for individuals in Willow Ward. The relatives that we spoke with felt that communication with ward staff throughout the restrictions had been helpful, although they said that having an agreed time and person to speak with would have been better. We were also told that with visits their family member had been supported, but that the frequency of visits had been limited.

However, a pressing matter for relatives and the existing care team members that we spoke to, related to the staffing requirements of the ward. The senior charge nurse (SCN) post has been vacant for a number of years and there is a shortfall of registered nurses in the team. As a consequence of this, there is a heavy reliance on ward staff doing overtime and bank staff being employed to fill the gaps in the rota.

This ward cares for a wide range of ages and people who present with highly complex behaviours. Consistency and leadership are necessary not only for the effective management of the ward but also in supporting the strategic development of the service, and in providing clinical support, supervision and development for the permanent staff team. While we were advised that plans are in place with an interim solution, we would suggest that employment of a substantive SCN for the unit be considered a priority.

We also heard that the complexity of the clinical needs for those being referred and admitted, often with comorbid diagnoses of learning disability and mental illness, presented a challenge for the unit. We were made aware that with the complexities of the patient group, there has been an increase in the number of assaults on staff, on the severity of these and an increase in the use of restraint. We discussed this on the day, and further follow up with the senior manager is ongoing.

We were advised that urgent referrals can often lead to admissions that in turn can present difficulties with discharge planning. We did appreciate that there have been developments in building the multi-professional team, and would recommend that there is further support provided to clarify and the required skill mix of staff and resources that can help develop a clear operational policy for the service.

Recommendation 1:

Managers should review the staffing resource necessary to support the clinical team in the strategic development of the service provided in Willow Ward.

Care and Treatment

Multidisciplinary team (MDT) meetings take place weekly. Decisions and outcomes from these meetings are clearly recorded. We noted that while there is clear evidence of psychiatry,

medical and nursing input, there is a lack of occupational therapy (OT), psychology and social work (SW) services to the ward. We found that where patients had been identified as ready for discharge, the relevant planning for legal safeguards, such as a guardianship order under the Adults with Incapacity (Scotland) Act 200 ('the AWI Act'), had not been put in place, thereby causing a delay.

In addition to the weekly MDT meetings, each patient has a core group meeting every six weeks, where the patient is invited to attend along with their advocate and family support networks. This gives the whole team of people supporting the patient an opportunity to discuss current care provision and be involved in discharge planning. These meetings are also well recorded.

Recommendation 2:

Managers should ensure there is a breadth of care and treatment available for patients, which includes the contribution of OT, psychology and SW. This should encompass both inpatient care and discharge planning.

On our previous visit to Willows in 2019, we made a recommendation in relation to care plans. Whilst there has been an improvement in the organisation of the files and in the care plans themselves, the quality of each care file that we reviewed varied and there was a lack of patient involvement. The care plan themselves were not consistently evaluated and in some care files, we were unable to find evidence of progress or deterioration; there was also a lack of detail about the effectiveness of which interventions had proved helpful.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 3:

Managers must ensure that a care plan audit system is established to monitor consistency and quality.

Use of mental health and incapacity legislation

We found all of the necessary documentation in relation to legislation was up-to-date, and well organised in the care files. We were able to locate all relevant paperwork for those patients who were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Treatment under the Mental Health Act for individuals who are not able to consent was present in all files was also easily located and accurate.

We found that measures relating to patients who had were specified persons was based on individual assessment, with the relevant legal paperwork and a reasoned opinion recorded in the files.

Where relevant, copies of welfare proxies for those patients on a guardianship order under the AWI Act were easy to locate in files. The section 47 certificates were all in date, with attached treatment plans and, where required, consultation had taken place with the proxy decision maker.

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/law-and-rights/rights-mind

Activity and occupation

We were pleased to see that for those patients who were ready for discharge to a community placement, there were external care providers coming to the ward, providing opportunities for the patient to engage in activities on and off the ward.

However, for those patients without established discharge plans, there was a lack of structured activity and a reliance on nursing staff to provide ongoing activity provision. This meant that activities for these patients was limited. Activity planners were not available for all patients and, where they were, there was a lack of information about what was offered and the outcome of this. We were concerned that there appeared to be a reliance on the nursing team to meet the activity aspects of patient's needs. We consider that this approach does not support meaningful engagement in activities that are essential to a patient's health, well-being and self-worth.

We heard that there is the option to refer patients to OT, but the focus is on assessment, where recommendations are made. With no dedicated activity co-ordinator employed in the ward, and limited input from OT, we would recommend t developing these roles rather than relying solely on the ward nurses.

Recommendation 4:

Managers should ensure that there is a range of therapeutic and recreational activities available for patients.

Physical environment

Willows Ward was not purpose-built for this patient group. It is situated on its own, away from the main hub of the hospital. We heard from staff that they can feel quite isolated and there have been concerns about staff and patient safety in the evening. The nurses' station is small and due to its location on the ward it can become a bottle neck as patients and/or visitors gather round the door.

Our first impression of the ward was that it appears dated, tired and, in some areas, lacking in facilities for the number of patients who are cared for there. Some of the communal areas were stark and uninviting, with minimal soft furnishings and accessories that would improve the environment. We discussed this with staff at the time of the visit. We were made aware that there had been advice given to the ward that some of the personalised items had to be removed due to potential infection control concerns as a result of Covid-19.

The design of the ward is one long corridor with a lounge at each end of the building and bedrooms, offices, meeting rooms and a treatment room off the main corridor. There is one lounge in the centre of the ward which leads to a sparse and poorly maintained garden. Opportunities to have access well designed and usable outdoor spaces offers patients therapeutic benefits; it is also an alternative environment place to meet with visitors and this is particularly useful during the current restricted visiting arrangements. There appears to have been little thought given to making the ward garden a pleasant or interesting place to be.

While all patients have their own bedroom, four patients have an en-suite, while two patients have their bathrooms directly off the main corridor. We heard from one of the patients that they found this to be an issue; with some redesign, this problem could be rectified so that all patients are able to have their own en-suite.

When increased observation for patients is required, as was noted on the day of our visit, and community based staff are visiting patients, both lounges can be busy. There is a lack of usable and comfortable communal space for the remaining patients and our impression was that most patients chose to spend their time in their rooms.

Recommendation 5:

Managers should address the environmental issues identified in this report.

Any other comments

We were concerned that there continues to be a lack of senior nursing leadership, representation and input from the wider multidisciplinary team.

We were advised that there the length of stay for some patients is in excess of 18 months, yet the remit of the unit is for assessment. There appears to be different views about the overall function and purpose of the unit.

Good practice

We were pleased to see the development of a one page profile that we found at the front of the care file, which provided a useful history and summative evaluation of each patient's stay on the ward. Covid-19 contingency plans have also been developed, and we noted that these were of a high standard.

Summary of recommendations

1. Managers should review the staffing resource necessary to support the clinical team in the strategic development of the service provided in Willow Ward.

2. Managers should ensure there is a breadth of care and treatment available for patients, which includes the contribution of OT, psychology and SW. This should encompass both inpatient care and discharge planning.

3. Managers must ensure that a care plan audit system is established to monitor consistency and quality.

4. Managers should ensure that there is a range of therapeutic and recreational activities available for patients.

5. Managers should address the environmental issues identified in this report.

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.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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 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 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: mwc.enquiries@nhs.scot
website: www.mwcscot.org.uk