Mental Welfare Commission for Scotland

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

Date of visit: 29 March 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Willows Ward is an assessment and treatment unit for six adults with a learning disability. We last visited this service on 7 October 2020 and made the following recommendations:

- Managers should review staffing levels;
- provide a range of care and treatment options;
- establish a care plan audit;
- make available a range of therapeutic and recreational activities
- review some environmental issues.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the environment of care in relation to incidents reported to the Mental Welfare Commission by relatives.

Who we met with

We met with and/or reviewed the care and treatment of five patients and five relatives/carers.

We spoke with the service manager, the charge nurse, psychiatrist and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Margo Fyfe, Senior Manager (practitioners)

What people told us and what we found

Care, treatment, support and participation

We were pleased to see the appointment of a new senior charge nurse and that staffing on the day looked generous. However, relatives advised that this was not always the case and ward staff acknowledged they struggled to achieve adequate core numbers to address the needs of this complex group of patients. We also heard that overtime and bank staff are regularly required to fill gaps in the rota. On further discussion with senior staff, the issue appeared to arise from the need to allocate nurses to individual patients on a one-to-one basis due to identified risks of harm from others. All patients had identified complex needs and this posed a number of difficulties whilst living in such close proximity to each other. We will return to this issue in the section discussing the ward environment.

Records of multidisciplinary meetings were regularly recorded; we found that many lacked sufficient detail and were short on information about forward planning. The personal information found in the 'Getting to Know Me' document, on the other hand, had plenty of detail about likes and dislikes, routines and interventions which provided a helpful background picture for each individual. The information was provided by relatives and other discussions with relatives were also generally well documented.

There were detailed risk assessment and management plans recorded and regular reviews were mainly in place. We also noted the detailed recording of regular one-to-one observations including any activities undertaken at these times. Since our last visit, there has been an improvement in input from occupational therapy, dietetics and psychological therapies to the ward, though vacancies still exist in these areas.

We observed that there was good attention to meeting physical health care needs in the ward. All patients have weekly access to a general practitioner, patients have annual health checks and appropriate health screening. This is particularly important for some patients with a range of complex health care conditions.

When we last visited the service there were detailed and person-centred care plans which addressed the full range of care for mental, physical, and the more general health and wellbeing needs of the patients. On this visit, we also found person centred care plans, though we did feel some of these lacked sufficient detail. We discussed this with the senior charge nurse and service manager who assured us further audits were planned. Nevertheless, it was good to see that many discharge care plans were in place, where appropriate, and the charge nurse had plans to develop further progress in this area. We look forward to seeing how this has improved at future visits.

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

Use of mental health and incapacity legislation

We found most of the necessary documentation in relation to legislation was up-to-date, and well organised in the care files. However, we were unable 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'). Some consent to treatment forms for medication needed updating. However, following discussion, these were promptly dealt with on the day of our visit. Furthermore, powers under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') were recorded on file including where there were increased powers of restriction.

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

The door to the ward was locked in keeping with the needs of the patient group.

On the day of our visit all but one of the patients required additional support with enhanced observation from nursing staff. For those subject to enhanced observations, the nursing team will carry out daily informal review of the level of observation and make contact with the medical team to discuss if there are particular concerns. Additionally, there is weekly review of enhanced observations at the ward round attended by multi-disciplinary members of the health and social care team. The medical and nursing staff discuss the patients' care and treatment to determine whether the observation level can be safely reduced. We were told that the team attempted to work with the patient to determine when enhanced observations can be reduced. This is to ensure that patients are not subject to an ongoing enhanced observation level unnecessarily.

Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions on file. Sections 281 to 286 of the MHA provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. One of the forms authorising restrictions was out of date but this was promptly attended to on the day of our visit.

Two patients had been subject to the use of seclusion for short periods. We found care plans that detailed the use of seclusion were clearly authorised in the medication administration chart, and documented in the seclusion and restraint recording chart. There was also clear evidence regarding the decision-making process related to how seclusion was being used, and also on alternative strategies used to try to prevent this level of restriction. However, we were informed that a policy on the use of seclusion is still not complete. The Commission recently updated its guidance on seclusion and this should be used to review local policy and procedures and ensure consistency of approach.

Advocacy services are available for patients though none attended on the day of the visit.

Recommendation 1:

Managers should ensure a policy on the use of seclusion is completed and a copy sent to the Commission.

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

Access to activities was one area of concern communicated to us by relatives and carers we spoke to. There is still a vacant post in the occupational therapy team leading to a shortfall in input. Furthermore, because of the level of clinical activity, nursing staff are a spending disproportionate amount of their time engaged in observation of individual patients with limited activity input. There appeared to be a discrepancy in provision of activities, which was felt by some relatives to be discriminatory and left some patients with little to do and a lack of access to outdoors. There is an outdoor space but it is not suitable as a garden area. To some relatives, it appeared that certain patients with increased clinical needs took up a disproportionate amount of staff time to the detriment of others. The lack of activity was perceived by some relatives to contribute to a feeling of boredom amongst patients who had formerly had busy programmes of activity prior to admission to hospital. Relatives were of the view that that this also contributed to frustration, agitation and increased levels of use of restraint and over use of 'as required' medication. Consequently, more staff were needed for one-to-one observation within the ward and fewer patients were able to go out. This was further compounded by a dedicated vehicle being unavailable due to an ongoing need for repairs.

Recommendation 2:

Managers should develop a range of meaningful activities on-ward, and off-ward and make these available to patients as appropriate.

The physical environment

The ward environment is the area which gave us most reason for concern. Willows is a stand-alone unit located some distance from the main body of the hospital. The conditions are cramped for the complexity of patient mix within the ward. And the harshness of the flooring enhanced any noise which was generated within the ward leading to an institutional ambience. Patients who come into conflict with others cannot be easily separated, leaving those who are, or have been, subject to assault by others, in a vulnerable position. According to relatives we spoke with, because of the lack of alternative quiet space, some patients spent most of the time in their room. Staff recalled that when the ward had been decanted into the main hospital for a period to allow for renovations, the larger ward area there had facilitated the separation of patients who were in conflict, which offered lots of alternative quiet spaces to patients. In Willows, there is insufficient quiet space to allow patients to choose where to go as an alternative to their bedrooms. The nurses also felt more supported by colleagues in the main hospital when located there, with wards which were close at hand and available to

provide assistance if needed. The outside space in Willows is also completely unsuitable and unfit for purpose with no garden area in the enclosed space.

Recommendation 3:

Managers should, as a matter of urgency, ensure there is an appropriate environment for the needs of this complex group of patients with suitable space (both indoors and outdoors) to allow nurses to keep patients safe and provide therapeutic care.

Summary of recommendations

1. Managers should ensure a policy on the use of seclusion is completed and a copy sent to the Commission.

2. Managers should develop a range of meaningful activities on-ward, and off-ward and make these available to patients as appropriate.

3. Managers should, as a matter of urgency, ensure there is an appropriate environment for the needs of this complex group of patients with suitable space (both indoors and outdoors) to allow nurses to keep patients safe and provide therapeutic care.

Good practice

The staff team at Willows are going through a transition period due to the number of new staff who have joined under the management of a new senior charge nurse. The service is continuing to recruit for vacant posts and continues to use regular bank staff. We were told that they are trying hard to recruit and support newly qualified staff which was positive. However, we are aware that this can place a demand on the more experienced staff. We spoke with a few of the staff who were enthusiastic and showed a real commitment and interest in working with people who have a learning disability and/or autism. We felt this was positive in the development of the staffing team in Willows. On the day of our visit we saw warm interactions between patients and staff.

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.

Suzanne McGuinness
Executive Director (Social Work)

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 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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