

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Acute Psychiatry Unit, Western Isles Hospital, Macaulay Road, Stornoway HS1 2AF

**Date of visit:** 19 April 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 during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, we are therefore undertaking a mix of virtual and face-to-face visits. This local visit was carried out face-to-face.

The Acute Psychiatry Unit in the Western Isles Hospital is a five-bedded unit and was fully occupied on the day of our visit. The unit has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, and psychology staff. Referrals can be made to all other services as and when required.

We last visited this service on 16 April 2019 when we made no recommendations.

On the day of this visit we wanted to follow up on some issues raised with Health Improvement Scotland and also to hear how patients and staff have managed throughout the current pandemic.

## Who we met with

We met with and/or reviewed the care and treatment of all five patients, none of whom were subject to compulsory treatment, and spoke with two relatives by phone.

We also met with the service manager, senior charge nurse, CAMHS manager and two CAMHS staff, community psychiatric nurses (CPN), social work staff and one of the consultant psychiatrists working within the service.

## Commission visitors

Doulas Seath, nursing officer

Margo Fyfe, senior manager (practitioners)

# What people told us and what we found

## Care, treatment, support and participation

### Nursing care plans

On admission, patients are tested for Covid-19 and if negative are able to leave their room. One nurse is allocated to care for the patient during this time. They can communicate with family and friends by using their mobile phones and iPads are also available to use if needed. Visiting is permitted by agreement and there is a separate entrance for use to reduce interaction with other wards.

The patients we spoke with were generally positive about the care they received. They told us that they feel well looked after and safe on the ward. They praised the staff for their support and felt they were always available to talk to if/when needed. Notes showed evidence of a good amount of one-to-one interaction with staff. One person said the atmosphere on the ward can change depending on the other patients and how unwell they are. They said if it feels overwhelming they go to their room for a while. One of the relatives felt that “staff were doing their best in difficult circumstances.” The patients can see their responsible medical officer (RMO) every week and attend the ward round if they wish.

On the visit, we found person centred care plans, though not always with sufficient detail, and there was not always clear evidence of patient and family involvement, though the latter was clearly happening as evidenced in the continuation notes. All files were in written format. The care plans followed on from initial risk assessments. We observed that initial risk assessments were not subject to regular review although were assured that risk is discussed at weekly medical reviews. We recommended that the full risk assessment should also be regularly reviewed. We saw that, together with full medical histories, physical health care needs were being addressed and followed up appropriately.

The multidisciplinary team (MDT) meetings which take place in the ward are well recorded, with a well-structured format being used. The meeting records have updates from mainly medical and nursing staff, with occasional input from other staff accessible to them. However, there is only limited input from occupational therapy (OT) and the clinical psychology post has just been filled. The MDT records reflect any input from patients, adding to discussions about their care and treatment, and have information about any actions or plans agreed. However, these actions do not always link to the care plans in place or refer to issues discussed in previous meetings, thereby losing a sense of continuity.

Advocacy services are available and some patients had taken up this option with positive feedback.

We were concerned to hear of the difficulties in accessing specialist treatments, which are not offered locally, especially electro-convulsive therapy, where this was the preferred option. This has led to unacceptably long waiting times for treatment.

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/node/1203>

#### Recommendation 1:

Managers should introduce regular audits of care plans to ensure that sufficient detail is included and that there is consistency in recording and review.

#### Recommendation 2:

### Managers should find a way to access preferred treatments off island, seeking appropriate assistance so that treatments can be delivered in a timely manner.

**Recommendation 3:**

Managers should ensure initial risk assessments are formally reviewed on a regular basis and recorded in case notes.

## Use of mental health and incapacity legislation

There were no patients subject to measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or Adults with Incapacity (Scotland) Act 2000 (the AWI Act) during the visit.

## Rights and restrictions

As mentioned earlier in relation to care planning, we saw evidence in files of initial risk assessments in place, ensuring that patients receive care in the least restrictive way possible.

The door into the ward was locked because the ward is situated in a community hospital, and to make sure that people cannot inadvertently access the unit, and particularly during the pandemic. However, patients did not report this to be restrictive in any way. There is good advocacy input into the ward, and patients we met on the visit confirmed that they either used advocacy support, or were aware that they could access this support.

The Commission has developed [*Rights in Mind*](https://www.mwcscot.org.uk/law-and-rights/rights-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 are aware that during the pandemic restrictions put in place meant that various activities in the unit had to be put on hold. We understand that access to activities has been further affected by staff shortages through recruitment difficulties and where staff need to self- isolate. There is an occupational therapist (OT) in post. However, the OT’s remit is to cover both hospital and community services. Nevertheless, we heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients. Now that restrictions are beginning to lift and patients are once again able to resume group activities, they are having to again adapt and cope with the changes in routine this brings them. We heard that staff have gone the extra mile to facilitate activity and ensure patients’ needs in this area are met.

## The physical environment

There is an attractive and comfortable lounge area and a useful activities room for the patients, both are bright and spacious. The environment was clean and airy and we were able to see where efforts have been made to personalise areas within the ward.

## Any other comments

Throughout the visit we saw kind and caring interactions between staff and patients. Staff we spoke with knew the patient group well. It was also good to note that patients we met with praised the staff highly.

During the pandemic restrictions, the drop in footfall in the unit benefitted the patients as they had less people to cope with in their living space. We heard that there have been no recent cases of Covid-19 on the unit. However, there have been cases in other parts of the hospital complex and this has created difficulties with new admissions and need for isolation. Patients remain in their room on admission until their Covid-19 status is determined. Once the test confirms they are free of infection they can mix with others. The door to the ward remains locked at present to prevent unplanned visits. Arranged visitors can exit directly via an alternative door.

We heard from community staff that there were difficulties in communication with the hospital in relation to discharge planning. We were concerned to hear that this has led to a discontinuity in care in several instances. In part, we were informed this results from the lack of an electronic record in the hospital so that information can be passed on in a timely manner. Additionally, due to their being no protocols in place to ensure procedures are followed systematically, staff are unsure about timescales involved.

#### Recommendation 4:

Managers should develop discharge planning protocols to ensure consistent procedures are followed in all cases.

**Summary of recommendations**

1. Managers should introduce regular audits of care plans to ensure that sufficient detail is included and that there is consistency in recording and review.
2. Managers should find a way to access preferred treatments off island**,** seeking appropriate assistance so that treatments can be delivered in a timely manner.
3. Managers should ensure initial risk assessments are formally reviewed on a regular basis and recorded in case notes.
4. Managers should develop discharge planning protocols to ensure consistent procedures are followed in all cases.

**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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