Mental Welfare Commission for Scotland

Report on announced visit to:

Islay Centre, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 3 October 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.

The Islay centre comprises of three units, with a total of 10 individualised areas that combine day/sleeping areas for the patients. In addition to this unit, there is Carnethy Ward that provides a service for another two patients. Both Islay and Carnethy are based in the grounds of the Royal Edinburgh Hospital.

These services currently provide assessment and treatment for patients with a learning disability, who have complex and challenging behaviours, often associated with a diagnosis of autistic spectrum disorder.

On the day of our visit there were 13 patients in Islay Unit and Carnethy Ward. At the time of our visit, there were seven patients whose discharge from the unit is delayed. A delayed discharge occurs when an inpatient who is clinically ready for discharge continues to occupy a bed, usually because of delays in securing a placement in a more appropriate setting.

We last visited this service on 4 June, 2019 and made recommendations in relation to the quality of information recorded in care plans, evaluation of long-term actions, the use of seclusion, the development of meaningful activities on the ward and a review of the environment to meet the needs of the patients.

On the day of this visit we wanted to follow up on the previous recommendations, to meet with patients, carers and staff as well as look at the care and treatment being provided on the unit.

Who we met with

We met with one patient and reviewed the care of six patients in total. We also met with or spoke to five sets of relatives.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN) and nursing staff.

Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

Comments from patients and relatives

The patient we met with on the day of the visit was extremely positive about their care and treatment in the unit. We heard that staff were caring, supportive and had good listening skills. The patient told us that they had a full timetable of activities they engaged in and enjoyed. We heard that that the patient's timetable was based on their likes and interests. The patient we spoke to told us that that they would like more opportunities to engage in skill building activities such as cooking, in order to prepare them for discharge to the community. They also told us they would like to be more involved in discussions and decisions relating to their care and treatment, that they were not invited to the MDT meeting and had not had any recent contact with their consultant psychiatrist. The patient added that they would like to attend this meeting and have the opportunity to meet with their consultant psychiatrist more regularly. The patient was recorded as having their discharge delayed and told us that they felt frustrated that support services were not available for them in the community; we heard that this meant the patient continues to be in an environment that is restrictive and does not help them progress with their care journey.

The carers and relatives we spoke to provided very positive feedback about the care and treatment their relatives were receiving in Islay Unit. The feedback included comments such as, "the communication from staff is good", "my relative is treated with dignity", "I feel listened to by staff and happy that my suggestions are listened too" and "there is good and supportive leadership in the ward".

The carers we spoke to did raise concerns that they did not feel involved in the MDT meetings and would like to participate in discussions and decisions about their relative. Some carers were unaware of future planning and felt concerned they their relative would spend an extended period of time in hospital. Other carers told us that there was a discharge plan for their relative, however added that this had been a long, and at times stressful process, due to a lack of community services available to meet the care and support needs of their relative.

Through discussion with staff and relatives, we were impressed to hear that there had been a strong emphasis to evaluate the clinical model of care in Islay Unit. Carers told us that they felt the quality of care and treatment for their relative had improved in recent years. We were pleased that the CNM and SCN were invested in developing practice that is less restrictive with greater emphasis on therapeutic intervention. The CNM and SCN discussed the importance of building a nurturing and supportive relationship with patients who have experienced adversity. They were committed to building staff skills and knowledge to ensure they have the necessary skills to deliver person centred, strengths based and solution focussed care.

Care records

Information on patient's care and treatment is held both electronically on TrakCare and in various paper files. We found this difficult to navigate and noted a lack of cohesion between paper and electronic files. We were of the view that the current recording system requires review to ensure all patient information is up-to-date and stored accurately. We discussed this

with the CNM and SCN on the day of the visit and were assured that the use of paper files would be reviewed as a matter of priority.

The information recorded in care records was detailed and personalised, providing a good sense of how each patient's day had been, what had been achieved and aspects of the day which had been difficult. There was evidence of frequent one-to-one interactions between the majority of the MDT and patients, and we were pleased to find that the case notes included regular communication with families and relevant professionals. However, after hearing from patients and relatives regarding contact with the consultant psychiatrist, we were unable to find any evidence of direct clinical review by the consultant psychiatrist.

Section 76 (1) of the Mental Health (Care and Treatment)(Scotland) Act 2003 (The Mental Health Act), provides that where a compulsory treatment order has been made in respect of a patient, the patient's responsible medical officer should prepare a care plan relating to the patient and include it in the patient's medical records. We were pleased to find that all patient files we reviewed had a copy of a S76 care plan.

One of the files we reviewed had a record of a 'liaison meeting'. This meeting was attended by the patient, many of the MDT and chaired by the discharge co-ordinator. The purpose of the meeting was to discuss future planning, the model of care being provided alongside any issues and / or positives aspects of the patients care and treatment. We were told that prior to Covid-19, liaison meetings were a regular occurrence in the unit. We were pleased to hear that these meetings had recently been recommenced.

Nursing care plans

Nursing care plans are tools which identify detailed plans of nursing care; this supports consistency and continuity with care and treatment. They should be regularly reviewed to provide a record of progress being made. The care and treatment plans we reviewed provided very comprehensive and detailed information, reflecting the complexity of the care which is being provided in the unit.

There was however inconsistent and limited evidence of discharge care planning. Given the amount of delayed discharges in the unit, we would expect to find robust discharge care plans with clearly identified goals.

In some patient files there were numerous care plans and we were concerned that current essential information was not easy to identify. However, we found the use of whiteboards that were located outside the patient's room, useful in providing essential information. The care plans reflected nursing interventions, but lacked a person-centred perspective and where possible, patient participation in this process. On the day of the visit, we raised concerns with the CNM and SCN that due to the volume of care plans that each patients had, they were not meaningful, regularly reviewed or easily implemented. We would expect care plans that evidence the current care and treatment, efficacy of goals, discharge planning and ensured the continuity of care. We were told that the unit are soon to be piloting a new 'Health and Recovery' tool which is records current and relevant information, is person-centred, includes a communication passport, weekly personalised timetable and encourages greater patient and family participation. We looking forward to hearing about the use of this 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/node/1203

Recommendation 1:
Managers should ensure care plan reviews are meaningful, include an evaluation on the effectiveness of interventions and reflect any changes in the individuals care needs.

Multidisciplinary team (MDT)

Care and treatment in the ward is provided by the MDT. In addition to the nursing staff, there is a part-time consultant psychiatrist, a part-time speciality doctor, two occupational therapists (OT), a part-time speech and language therapist (SALT), pharmacy, an art therapist and three recreational assistant. We noted that at the time of this visit, the majority of the patients had an allocated mental health officer and/or a social worker. We were concerned to hear of the lack of medical staff for the unit and how this impacts on each patient's medical review.

Until recently, Islay Unit had a part-time psychologist that had a key role in creating and implementing Positive Behaviour Support (PBS) plans for patients in the unit. Some of the files we read contained PBS plans that included both proactive and reactive strategies to manage the patient's behaviours. The plans gave the staff detailed and practical strategies for managing patient's complex care needs. However, the use of PBS was not consistent for all patients due to limited psychology input. We heard on the day of the visit that the psychologist had now left post and there is presently no replacement, due to recruitment issues. In light of the complex needs of the patient group in the Islay Unit and the importance of psychological input to support the group of patient's care and treatment, the recruitment to this post should be prioritised.

The MDT meetings takes place weekly. The patient group is split into two groups and each group of patients discussed on a fortnightly basis. We noted the Care Programme Approach (CPA) is used to review care and treatment for some patients in the unit, however the CPA paperwork we reviewed was not current. CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. The SCN told us that CPA is not currently used for all patients and patients who are subject to CPA have not been reviewed regularly. A CPA Co-ordinator is now in post and the aim is for all patient's care to be reviewed using CPA which will then ensure regular reviews. We will monitor this on future visits.

We made a recommendation in the previous report in relation to the quality of MDT information recorded in the COREPLAN, especially in relation to evaluation of long-term actions. We were disappointed that although reviewed in a timely manner, the information recorded in the COREPLAN was basic and often stated "no change". Given the complexity of the care provided, and the primary function of the ward as an assessment and treatment service, we would have expected these reviews to be more robust, identify progress and to target nursing intervention.

We also noted when reviewing the MDT documentation that there was limited participation from the patients and their carers in MDT discussion and decision making. If patients were unable to be involved in their own care planning, we would like to see the reason for this recorded and this regularly reviewed.

Recommendation 2:
Managers should urgently review the medical and psychology provision to the unit.

Recommendation: 3
Managers should review the quality of the information recorded in the COREPLAN, ensuring that it identifies progress and includes details of future planning.

Recommendation: 4
Managers should ensure patients and carers have the opportunity to attend MDT meetings and participate in discussions and decisions in relation to care and treatment.

Use of mental health and incapacity legislation

On the day of our visit, all of the patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patient we met with during our visit had a good understanding of their detained status under the Mental Health Act. Many of the patients were subject to the Adults with Incapacity (Scotland) Act 2000 (AWIA).

All documentation pertaining to the MHA and AWIA was either recorded on TRAK or in paper files and was up-to-date.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Part 16 of the MHA sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed. We found that most of the T3 certificates were available and up-to-date. We identified one T3 certificate that did not authorise medication prescribed. We raised this on the day of the visit with the SCN, and we will follow this up with the RMO.

On the day of the visit, we found that patients who were subject to AWIA legislation had the details of welfare proxies and the powers granted in the welfare and/or financial guardianship in their files. The patient we met with had a good understanding of what guardianship under the AWIA meant for them.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWIA must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision

maker and record this on the form. From the files we reviewed, we were unable to locate a s47 certificate in one of them. We raised this with the CNM and SCN on the day of the visit, who agreed to follow this up urgently.

Rights and restrictions

Islay Unit operates a locked door, commensurate with the level of risk identified in the patient group. Information on the locked door policy is available at the main entrance to the unit. There were individual detailed risk assessments in place for patients that set out the arrangements for time off the ward and the support required to facilitate this safely.

On the day of our visit there were some patients on enhanced levels of observation and we heard that the level of enhanced observations in the ward was generally high. We noted that for some of the patients who were subject to enhanced observation, this had been in place for prolonged periods. NHS Lothian's Standard Operating Procedure: The practice of continuous interventions in mental health wards, was developed and influenced by the Scottish Patient Safety Programme's 'Improving Observation Practice' guidance. Both documents recommend that this high level of intervention should be reviewed regularly to assess its effectiveness and promote a framework of practice that is proactive, responsive and personalised. We found limited evidence of these review processes being conducted. On the day of the visit, we found variable levels of interaction between staff and those patients who were on continuous intervention.

We observed two patients who had CCTV cameras in their rooms. We were told that the purpose of the CCTV is to monitor and observe the patients due to clinical risks and was proportionate to the assessed level of risk. We raised concerns with the SCN that the CCTV appeared to be being used in place of staff contact; we thought that the disproportionate use of CCTV could be considered to be an intrusion into an individual's privacy and dignity which is protected by Article 8 of the European Convention on Human Rights. The presence of a camera may be deemed as a threat to an individual's privacy and must be proportionate, lawful and be used with a legitimate aim. We will follow these matters up with the relevant RMO.

We made a recommendation in the previous report in relation to the unit developing a consistent approach in the use of seclusion. We were pleased to find that some improvement has been made. The SCN told us that the overall use of seclusion in the unit had reduced and this had been mainly attributed to the development of safe spaces. However, we do continue have concerns. Two of the areas in Islay Unit had a seclusion room (Barra and Rhum) however Harris does not. Therefore patients in Harris who required the use of the seclusion room, had to leave the building when in a highly distressed state. We were concerned about the safety of this practice for the patient and staff and also the dignity of the patient during transfer. Another area of concern we had was around patients who were in rooms with locked doors. We were able to review the seclusion care plan which recorded the requirement for this practice, however we were concerned that there was no regular evaluation to ensure that this restrictive intervention was only applied for the shortest time necessary.

Our seclusion good practice guidance is available on our website at:
https://www.mwcscot.org.uk/node/1243

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. None of the patients in the Islay unit had an advance statement in their file. We found that other patients had limited knowledge of what advanced statements were. We discussed with the CNM and SCN the responsibility health boards have for promoting advanced statements as they are a way of ensuring that people with mental ill health, a learning disability and autism are listened too, their rights respected and gives them the opportunity to record their decisions and choices about their future care and treatment. We made suggestions of how advanced statements could be promoted in the ward and the importance of recording the reasons if a patient declined to make an advanced statement.

Our advance statement good practice guidance is available on our website https://www.mwcscot.org.uk/node/241

We heard from the patient and staff that advocacy support was readily available. Partners in Advocacy attend regularly and we were pleased to hear that they have regular discussion with the MDT regarding how best to engage with patients to ensure the advocacy support is of benefit. Advocacy support patients who were involved in discharge planning and attends these meetings. Advocacy also attends the liaison meetings that take place in the unit.

We were pleased to note that many of the files we reviewed recorded that the patients had legal representation. For those patients unable to organise legal representation, a curator ad litem had been requested to safeguard the interests of the patient in proceedings before the Mental Health Tribunal for Scotland.

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

Recommendation 5:
Managers should ensure that the need for enhanced observation is clearly recorded, regularly reviewed and staff have access to and are conversant with the observation policy.

Recommendation 6:
Managers should urgently review the seclusion policy and its application to ensure that seclusion is only used when required and patients subject to seclusion undergo regular MDT review.

Recommendation 7:
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this. These discussions should be clearly documented within the patient's clinical notes, along with a copy of any advance statement.

Activity and occupation

The Islay unit had three dedicated Band 3 recreational assistants. We heard the role of the recreational assistant is to support patients to develop individual activity planners that include

social, recreational, and rehabilitation activities. These activities were delivered both in the ward and in the community, supported by staff where appropriate. The SCN told us that Covid-19 has had an impact on some patient's confidence to go out of the unit and staff were continuing to offer support to build patient's confidence, in order to feel safe in the community.

The activities available in the unit include access to art therapy, input from Cyrennian's garden project, horse riding, swimming, cycling and therapets. In addition, we saw a number of patients who were supported by private providers as part of a transition preparation in working towards discharge.

In some of the files we read, there was limited evidence of activity recorded. We were disappointed to find that the recreational assistants do not record activities in the patient's file. This made it difficult to locate information about the activities patients were engaging in and any progress being made.

We made a recommendation in the previous report in relation to the development of more meaningful activities in the ward setting. The SCN told us that there had been some progress in this area, however highlighted to us that some patients prefer to have some free time in the evening. Other patients liked to engage in activities at this time of day, but staff advised us that activities were not meaningful and those that were chosen were of a historical option. The SCN told us that the focus remained for each patient to have an activity timetable which was personalised to their likes and interests, meaningful and was reviewed regularly.

Recommendation 8:
Managers should ensure that all patient activity participation is recorded and evaluated.

The physical environment

Islay is made up of three units, Harris, Rhum and Barra; each unit is accessed separately. Harris can accommodate three patients, with Rhum and Barra Units accommodating four patients per unit. Each unit had individual 'pods' that has a bed space and en-suite facilities. The pods vary in size with some having room for a small living area i.e. TV and sofa. Each pod had access to an outdoor garden area. We observed the unit to have a high standard of cleanliness.

We were able to view some of the pods on the day of the visit and saw that some were decorated to the patient's personal taste. Other pods were sparsely decorated. While there was clinical justification for the sparseness of some patient environments, we were concerned to hear that there has been prolonged delays in requests that had been made to the Royal Edinburgh Hospital estates department for items such as curtains, sound proofing, and sensory areas. These items had been requested to make the patient's environment more homely and therapeutic.

In a previous report, we made recommendations regarding the environment meeting the needs of the patients. We were disappointed to see that limited progress has been made with the environment. There were areas where décor needs to be refreshed and repairs are required. We heard from the SCN and CNM that efforts have been made to create more therapeutic areas in the unit, however this has been difficult due to a lack of space. During the visit, we saw how limited the space was for staff and patients.

Recommendation 9:
Managers should ensure that a system is in place to ensure maintenance requests are responded to within a reasonable timeframe which allows for escalation if necessary.

Recommendation 10:
Managers should address the outstanding environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Any other comments

During discussions with the CNM, the SCN and nursing staff, we were told that they have concerns over the number of staffing vacancies in the unit. There were 20 Band 2 health care support worker vacancies in addition to other posts that are vacant. The unit relies on regular use of bank and agency staff. Nursing staff raised concerns that bank and agency staff do not always have the necessary training and experience to work with the complex patient group in Islay Unit. We were pleased to hear that generally core staff cover the majority of bank shifts. While this is beneficial for consistency of care for the patients, there is a concern that working additional shifts will negatively impact on staff wellbeing. The CNM told us that there was an ongoing recruitment programme however highlighted that there has been a poor uptake with the recent recruitment drives.

From the discussions we had with staff, we were pleased to hear then even though the unit was experiencing staff shortages, staff reported that they feel part of a supportive team and remain committed to offering high levels of care and treatment to the patients in Islay Unit.

We heard that staff were given the opportunity to engage regularly with psychological sessions to engage in mentalisation techniques. We heard that staff find this support beneficial as it provides a safe space and an opportunity to reflect on practice issues.

We heard there were ongoing training opportunities for staff. Four nursing staff have completed a post graduate qualification in Positive Behavioural Support (PBS) with more staff undertaking this training this year. We were encouraged to hear that all staff will complete Improving Practise training, produced by NHS Education for Scotland. This training is underpinned by PBS principles and focusses on values and attitudes. There remains a concern that the lack of psychology support in the ward will impact on the ability to implement PBS as it requires practitioners to be supervised by psychology staff.

Summary of recommendations

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Recommendation: 3
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Managers should ensure that the need for enhanced observation is clearly recorded, regularly reviewed and staff have access to and are conversant with the observation policy.

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Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this. These discussions should be clearly documented within the patient's clinical notes, along with a copy of any advance statement.

Recommendation 8:
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Managers should ensure that a system is in place to ensure maintenance requests are responded to within a reasonable timeframe which allows for escalation if necessary.

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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
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 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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