Mental Welfare Commission for Scotland

Report on unannounced visit to: Gigha Forensic Rehabilitation and Iona Low Secure Wards, Beckford Lodge, Caird Street, Hamilton ML3 0AL

Date of visit: 25 January 2023

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 and unannounced.

Gigha Ward is a 12-bedded, mixed-sex forensic rehabilitation unit in the purpose built Beckford Lodge site. The ward provides a step-down service from the low secure forensic wards. On the day of our visit there were 12 patients.

Iona Ward is a purpose-built, low secure forensic mental health ward providing care and treatment for male forensic patients across NHS Lanarkshire. On the day of our visit there were 15 patients and six patients waiting to transfer into the ward when beds become available.

Patients from both wards had access to Caird House in the Beckford Lodge grounds where they had the use of a kitchen for group work, a large outdoor garden area with access to gardening activities, outdoor seating, and access to a bicycle maintenance shed. There was also a studio in the grounds to allow for art project work with the patients.

We last visited this service on 15 June 2021 and made a recommendation on patient participation in care plan reviews. The response we received from the service was that this had been reviewed and rectified.

On the day of this visit we wanted to follow up on the previous recommendation and hear from patients and staff how they are managing with the easing of pandemic restrictions.

Who we met with

We met with, and reviewed the care of 13 patients, 11 who we met with in person and two who we reviewed the care notes of. We also met with two relatives.

We spoke with the acting senior charge nurse, charge nurses and staff nurses from both wards as well as briefly speaking with both consultant psychiatrists.

Commission visitors

Margo Fyfe, senior manager

Lesley Paterson, senior manager

Douglas Seath, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support and participation

We had the opportunity to meet with patients from both wards, and all patients that we met with were complimentary of staff support and availability. They commented that although busy, staff always had time to spend with the patients when they needed them. We saw evidence of this; where some patients required quite a bit of staff time, this was given with care and support to meet the patients' needs.

Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patient group well and had a good knowledge of their patients' needs, care and treatment.

We heard that patients were happy to be getting back to their external activities, supported by staff, since restrictions imposed by the pandemic were lifting.

The patients were aware of their rights and had access to advocacy services as regularly as they wished. We heard that advocacy were once again visiting the wards and looking to restart the group sessions that had been in place, pre-pandemic.

In both wards where patients had discharge plans in place, they were aware of these. Of the 12 patients in Gigha Ward, six had housing identified for discharge but are awaiting support packages being put in place as there have been delays in recruiting staff. Four patients in this ward were delayed discharges. In Iona Ward three patients were waiting on housing. The delayed discharge team were involved in the discharge process and there were regular meetings with housing and social work colleagues.

All patients were managed under the care programme approach (CPA) with regular meetings for patients and families/carers, and where patients were in agreement, they were invited to attend. Patients from both wards told us that they were aware of their CPA meetings and forward plans.

Care records

As at the time of our last visit we found progress notes and one-to-one notes in both wards to be clear, person-centred and informative. These notes were recorded on the Situation, Background, Assessment and Recommendation (SBAR) format in Gigha Ward but this was not used in Iona Ward.

In Iona Ward, all care information was held in paper files. Information is held over several files for each patient. When we last visited, we suggested, for ease of locating information, that there was a clear note at the front of the main file detailing where all information was located. Unfortunately this had not changed, which meant searching through files to locate information. Again we suggested having a note at the front of the main file indicating where information was located. It is not clear why this ward have not moved to the electronic record system in line with the rest of the mental health service.

Gigha Ward notes are on the electronic record system MORS. Records were easy to navigate and information was easily located. We were concerned about this lack of continuity in the

patient recording system across the mental health service and recommended that managers address this situation with some urgency.

Risk assessments in both wards were easy to find, completed and regularly reviewed. We asked about level 2 risk assessments and were informed that these more in-depth risk assessments were in place for all patients who were subject to restriction orders. We heard that in Gigha Ward, these were reviewed three monthly. In Iona these were reviewed six monthly and for non-restricted patients these higher level risk assessments were under review where deemed appropriate by the multidisciplinary team.

Recommendation 1:
Managers should urgently address the issue of electronic and paper patient record systems to ensure all of the mental health services are using the same record system.

Care plans

We were pleased to see that care plans in both wards continued to meet the high standard of care planning set by the service in recent years. The care plans contained the individual patient's views and wishes in regard to their mental health journey, status, and goals. In both wards patients were able to tell us about their care plans and said they had been involved in compiling them.

In Gigha Ward, reviews were happening regularly, and we were pleased to see it was clear from the written reviews that the patients had participated in the process. We were also pleased to see easy-read care plans in place for the patients that needed this.

Unfortunately in the patient files we looked at in Iona Ward, we could not find any written reviews. When we asked staff to locate these; they could not find them either. There was a clear awareness of reviews happening but this was not being reflected in the paperwork. Care plans are not static and need regular review in line with multidisciplinary meeting decisions and patient progress. We recommend urgent improvement in the review process ensuring appropriate recording in patient files.

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 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

We saw that physical health care needs were being addressed and followed up appropriately in both wards.

Multidisciplinary team (MDT)

The wards have a multidisciplinary team (MDT) of consultant psychiatrists, junior doctors, nurses, psychology, and occupational therapy. Pharmacy are available for telephone advice. Other disciplines are accessed via referral. One patient did not have an allocated mental health officer which we will follow up on separately. All mental health officers along with community staff when appropriate, are invited to attend MDT meetings. Throughout the pandemic these meetings have taken place via TEAMS. We were told that patients and carers are asked if they wish to contribute to the meetings but have been unable to attend. We were informed that there has been discussion around returning the meetings to face-to-face, which will allow patients, and where they wish family/carers, to participate directly. We look forward to hearing how this progresses when we next visit

We were pleased to see that in Gigha Ward the MDT meeting was recorded on the standard form. This ensured the discussions are fully recorded. MDT meeting notes were clear and relevant.

These were not so easy to locate in paper files in Iona ward as there were brief notes in the daily file, with psychiatrists keeping notes in the medical file and a more detailed meeting note held on a separate drive on the computer system. This again led to confusion, with several places used to store information. We recommended that both wards use the standard MDT meeting form and store these in patient files in Iona, and in a dedicated file in Gigha, for ease of access and to avoid information being lost or written several times.

We heard that during the pandemic all MDT meetings had been held electronically on TEAMS. There have been ongoing discussions regarding bringing these back to face-to-face meetings to ensure that patients and if they wish, families/carers, can attend. It is our view that patients have the right to attend these meetings and every opportunity should be taken to ensure that this option is available to patients and where they wish family/carers to attend. We look forward to hearing how this progresses when we next visit.

Recommendation 3:
Managers should review the recording of MDT meetings and ensure both wards use the appropriate format and that this information is stored consistently for ease of access of staff.

Use of mental health and incapacity legislation

Similar to our last visit, we found all legal documentation to be in order and easy to access on both wards. The information sheet at the front of files that indicated review/expiry dates was helpful.

We found all consent to treatment forms in place as required under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). On the day of our visit, as we would have expected in a low secure setting, all patients in the wards were detained under the Mental Health Act. The patients we met with during our visit had a good understanding of their detained status.

Part 16 of the Mental Health Act 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 in Gigha Ward. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date. In Iona ward we found several discrepancies between prescribed medication and that which was authorised by T2/T3 certificates. We were able to speak with the consultant psychiatrists about this on the day who immediately dealt with the issues.

Recommendation 4:
Managers should ensure there is a robust audit system in place to ensure all consent to treatment documentation is up to date with prescribed medication.

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.

Rights and restrictions

The door to Gigha Ward, is unlocked and patients can come and go freely. In Iona low secure ward the door is locked. There is information on the wall at the entrance of the ward that describes why the door is locked and how to exit.

At the time of this visit there were no patients on enhanced observations in either ward. However staff were able to tell us how they now work in line with Commission good practice guidance. We were aware of the work that has been done in Iona Ward in relation to the new observation policy in NHS Lanarkshire, in conjunction with Health Improvement Scotland guidance on improving observation practice. Staff spend time with patients engaging in meaningful activity, giving support and reassurance and engaging with the patients' needs during times of enhanced observation. We were informed that explanations are given to patients and clearly documented in care files when enhanced observations are in use. The unit does not use seclusion to manage any patients.

Advocacy services are available and encouraged. During the pandemic, advocacy staff were available by telephone but have since returned to face-to-face visiting in the wards.

Where specified person restrictions were in place under the MHA we found reasoned opinions in place. Sections 281 to 286 of the MHA provide a framework in 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.

We noted specified person forms and reasoned opinions where applicable in Gigha Ward. In Iona Ward we found these in all care files and noted that the Commission were sent copies of the forms and reasoned opinions when restrictions were put in place. We queried why there was a separate file that had many out-of-date forms in it, when forms were also stored in the patient files and appeared more up-to-date. We recommended ensuring up-to-date forms were stored in patients' files, with older forms appropriately archived.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 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. We noted some in files during this visit and encouraged staff to discuss the use of advance statements more with patients as their mental health improves.

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 the changes to available activities due to the restrictions of the pandemic, had reverting back to what they were for both wards. We heard of the broad range and variety of activities that have been on offer, and that patients have been involved in planning these. Patients we met with were clear about what was happening and about what was available to them on a day-to-day basis. They spoke about activities on the wards, in Caird House, in the grounds and the local area. Both wards have a history of providing a high level of activity for patients, with occupational therapy staff managing to ensure community access to activity on both on a social/recreational and therapeutic basis. We commend the ongoing attention to this area of patient care and support.

The physical environment

The physical environment is unchanged from previous visits. The unit is purpose built with single en-suite bedrooms.

In Gigha, all bedrooms are single en-suite. Patients are encouraged to personalise their rooms. The unit has four lounge areas, activity space, assessment kitchens, and laundry facilities for patient use. Iona ward has 15 en-suite bedrooms, and again, patients are encouraged to personalise their own space. The ward has an activity area, three lounges, and a gym for patient use. There is enclosed outside space that patients can access directly from the ward.

There is space for activity both therapeutic and recreational and relaxation as well as access to enclosed and open garden space that the patients help to maintain.

Décor is in good order and patients are encouraged to personalise their own bedrooms.

Any other comments

Prior to the visit, relatives that we had spoken with had raised concerns about the lack of communication with them from the ward and felt that they had no regular mechanism for providing input into their family member's care and treatment. We discussed this on the day of the visit and were pleased to hear about efforts being made to include families/carers and to communicate with them more regularly. We also heard about the carers' group that used to be run by nursing and occupational therapy staff that has recently started up again and how families/carers will be encouraged to use this support. We look forward to hearing how this progresses when we next visit.

Staffing

We heard that Iona ward is benefitting from having two consultant psychiatrists in place. We were aware there had been issues regarding sickness/absence however staff were in the process of in the process of returning to work which will help the wards return to the usual working pattern. As at the time of our last visit we heard that there have also been quite a few changes in nursing staff and that there are several vacancies and a high level of absence due to Covid-19 illness over the autumn and winter that has led to the higher use of bank staff. It is hoped that the service will be able to recruit more nursing staff from the current recruitment drive. We look forward to hearing how this has progressed at future visits.

The Commission are aware of the staffing issues throughout Scotland and have written to Scottish Government raising our concerns.

Summary of recommendations

Recommendation 1:
Managers should urgently address the issue of electronic and paper patient record systems to ensure all of the mental health services are using the same record system.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 3:
Managers should review the recording of MDT meetings and ensure both wards use the appropriate format and that this information is stored consistently for ease of access of staff.

Recommendation 4:
Managers should ensure there is a robust audit system in place to ensure all consent to treatment documentation is up to date with prescribed medication.

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.

Contact details

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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk