Mental Welfare Commission for Scotland

Report on an unannounced visit to: Acute Psychiatry Unit, Western Isles Hospital, Macauley Road, Stornoway, HS1 2AF

Date of visit: 17 October 2023

Where we visited

As part of a series of visits to more rural adult acute inpatient admission wards, the Commission undertook an unannounced visit, commencing in early evening and continuing into the morning of the following day, to better understand what activities were available, and how care and treatment was provided in settings that did not have the same access to facilities available in more urban inpatient units.

The Adult Psychiatry Unit in the Western Isles is a five-bedded adult acute mental health assessment ward, providing care and treatment for males and females. The ward covers the catchment area of the whole of the Western Isles. On the day of the visit, there were three patients in the ward.

We last visited the ward on 19 April 2022 and made recommendations in relation to care plans, access to off-island placements, risk assessments, and discharge planning. On the day of this visit, we wanted to follow up on the previous recommendations as well as look at the range of care and treatment provided on the ward.

Who we met with

We met with and reviewed the care of all three patients. We did not meet any relatives or carers on the day of this unannounced visit. We discussed with the senior charge nurse that we would be happy to make contact with any relatives or carers following the visit, if they wished. We spoke with the associate nurse director, senior charge nurse (SCN) and staff nurses.

Commission visitors

Douglas Seath, nursing officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

Comments from the patients about staff in the ward were positive, acknowledging that the input that was provided was done so in a supportive and helpful manner. Staff that we spoke with knew the patient group well. Patients told us that they had a named nurse and one-to-one meetings with staff that took place on a regular basis, and we found this evidenced in the notes on file. There were documented records of patients being involved in their care and treatment and communication with relatives was regularly maintained.

We heard from staff that there were challenges as a result of low staffing numbers, and that this had an impact on patient care. We were told that staffing was, and is exceptionally difficult at times, mainly due to vacancies, annual leave, and a shortage of qualified and non-qualified nurses on every shift. Although this is improving, and new staff should be available soon, there are regularly bank and agency staff used to cover the shifts. Opportunities to find additional staff are limited and often staff are provided to the detriment of other local NHS services, such as liaison psychiatry and community mental health nursing. Attracting newly qualified and experienced registered mental health nurses to the Western Isles has proven to be difficult. Staffing challenges were acknowledged by managers, who were actively trying to recruit and retain staff, but recognised this was an issue nationally.

Staffing in other areas is equally challenging with locum psychiatrists now being routinely used, though they do appear to remain in post for a good length of time. The clinical psychology post, recently filled on a temporary basis, is now vacant once again. Applicants almost always ask if the post could be covered remotely, but this has been resisted by senior management. The occupational therapy provision is less than full time and covers all mental health services.

On our previous visit, we were concerned at the delay in finding and accessing appropriate specialist services for electro-convulsive therapy which were not available locally. On this visit, the difficulty in finding specialist beds was increasingly apparent, with a need for an intensive psychiatric care unit and specialist older peoples' ward. There is no service level agreement in place for either of those with another health board and this has created difficulties as an increase in nurse staffing levels is required to deal with the situation when it has arisen.

Recommendation 1:
Managers should put in place a means to access specialist beds so that transfers can occur in a timely fashion.

Care records

We found the written records relatively easy to navigate. It was clear to see where specific information was located, including Mental Health Act legislation. All staff involved in the patient's care were able to input into the record which helped with continuity of care, communication and information sharing.

The information held in the daily care records was of a high standard. Care records provided detailed and personalised information that included how the patient presented throughout the day, what they had accomplished, and aspects of the day that had been difficult. Entries

related to care plans which focussed on presenting assessed need and were detailed and informative.

Recording of one-to-one interactions between patients and nursing staff was clearly documented in care files. These provided a high level of detail of the discussion that had taken place between patient and named nurse.

We found the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk. Updates were recorded in the weekly reviews and on discharge, acknowledgment of where changes had occurred.

Nursing staff in the adult psychiatry unit continue to use three levels of observation, with an information leaflet to this effect posted on the noticeboard for relatives. This is based on the *'Engaging People' guidance* (2002). The Scottish Patient Safety Programme (SPSP) has produced *'Improving Observation Practice'* (IOP), which provides more up-to-date guidance that moves away from centralising the use of observation status. IOP determines and describes the nature and extent of care, treatment and safety planning, and associated interventions and interactions that an individual requires; care, treatment and safety planning are guided by the identified specific clinical needs of the individual. The guidance aims to extend and build on existing good practice in mental health services to provide an improved model of person-centred care that can be applied in any healthcare setting.

We noted that there was a level of observation in place which effectively amounted to use of seclusion level 2. There was no policy in place for use of seclusion, protocol to implement, or care plan to ensure regular review in line with good practice guidance.

The Commission has produced the good practice guide *Use of seclusion* in this area.

Recommendation 2:
Managers should ensure that nursing staff base their observation practice on SPSP guidance and alter their policy accordingly.

Recommendation 3:
Managers should put in place a policy to regulate the use of seclusion and implement a protocol for its use to ensure patients' rights are upheld at all times.

Nursing care plans

Nursing care plans are a tool, which identify detailed plans of nursing care, and effective care plans ensure there is consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

When we last visited the service, we found the care plans in place to be variable with some lacking sufficient detail to show evidence of patient and family involvement.

On this visit, we found more recovery-focussed care plans with greater detail in relation to interventions that were required to meet identified goals. These were evaluated weekly and signed by the patient or reasons given why this could not be achieved.

Multidisciplinary team (MDT)

The ward had an MDT on site consisting of nursing staff, psychiatrists, occupational therapy (OT), and until recently, clinical psychology staff. Referrals were made to all other services, especially physiotherapy, as and when required.

The consultant psychiatrist held a weekly ward round in the unit. It was clear from the detailed and consistent MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and update on their views and involvement.

A specific MDT proforma was in use, which documented all those in attendance. We found these provided a detailed, holistic review with a good indication of each patient's presentation over the past week. We found detailed plans, outcomes and areas of focus recorded. The risk assessment of each patient was also updated at this time and recorded in the proforma.

Patients and family/carers were invited to attend the ward rounds and were allocated a timeslot in advance. We saw good evidence of patient involvement, though some chose not to attend or were too unwell to do so. We heard that if they chose not to attend the meeting, their doctor would meet with them afterwards to provide feedback. We saw some evidence of family/carer involvement.

We saw detailed input from OT and clinical psychology staff in the records, and those who received input were appreciative of this. It is unfortunate that the post of clinical psychology could only be covered on a temporary basis and that this secondment has now ended. There have been offers to fill the post from individuals who would be willing to carry out the role by video rather than in person, but senior managers for the service have not approved this.

Recommendation 4:
Managers should prioritise recruitment of clinical psychology staff and should consider all possible options to fill the post where applications are limited.

Use of mental health and incapacity legislation

On the day of our visit, two patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status.

All documentation relating to the Mental Health Act was in order and easily located in files.

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. We reviewed all patients' consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found one instance where medication was prescribed that was not authorised on a T3 certificate; we highlighted this on the day of our visit.

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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (the AWI Act) 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. We noted that one patient was identified as having a s47 certificate in place. On review of the certificate, we noted that it had expired. We raised this with the SCN on the day of the visit and requested an urgent review of the need for a s47 certificate for this patient.

In line with the AWI Act, there is a need to ensure a clear process to identify when there was a welfare proxy in place. We were pleased to note that where a proxy existed, a record of this and acknowledgement of their role was evident.

Under the AWI Act there is also the need to ensure a clear process is in place to identify when an adult lacks capacity to consent to medical treatment. Where this is the case, staff should ensure that the responsible doctor signs a s47 certificate to authorise any medical treatment given. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found no evidence of a certificate in one case where it was required.

Recommendation 5:
Managers should ensure that, where a patient lacks capacity in relation to decisions about medical treatment s47 certificates, and where necessary, treatment plans must be completed and cover all relevant medical treatment the individual is receiving.

Rights and restrictions

The adult psychiatric unit continued to operate a locked door policy; however, this is commensurate with the level of risk identified with the patient group and there were instructions by the door that explained how entry and exit was facilitated.

The patients we spoke to on the day of our visit had a good understanding of their rights. Advocacy services were available on a referral basis and we were pleased that the patients we met with on the day were aware of advocacy support, if they wished to use it.

Sections 281 to 286 of the Mental Health Act 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 be applied. There were no patients subject to such restrictions at the time of our visit.

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

On our last visit to the ward, we noted that there was an occupational therapist in post but that this post was for all psychiatric services in the area, and this was still the arrangement at the time of this visit. This results in a limited service for inpatients, though there was evidence of individual work taking place where it was indicated. Nursing staff provide activities and there is ample space for these to take place. However, it is subject to the clinical demands of patients at any given time and the availability of staff to carry out the function.

We saw an activity timetable in place, but patients we spoke to were not always aware of the activities that were on offer and often experienced feelings of boredom in the ward. There was no access to a gym, although there was evidence of activities that took place in the form of artwork on display.

The physical environment

The ward consisted of five single bedrooms, which were all suitable for disabled access. There was a lounge area, activity space and a quiet area. On our last visit, the shared dining area was not being used due to Covid-19 restrictions.

The ward felt calm on the day of our visit. It was bright, spacious and clean, though in need of some decoration. There were a few rooms available for quiet space, meetings and visiting. We were pleased to see that patients were encouraged to personalise their bedrooms.

There was a laundry room available and a small kitchen area for patient use. This was open for use and had provisions for patients to make themselves hot drinks or snacks throughout the day.

The ward had an enclosed garden, shared with other wards, that was large and well maintained. We heard that it was in frequent use in good weather.

Summary of recommendations

Recommendation 1:
Managers should put in place a means to access specialist beds so that transfers can occur in a timely fashion.

Recommendation 2:
Managers should ensure that nursing staff base their observation practice on SPSP guidance and alter their policy accordingly.

Recommendation 3:
Managers should put in place a policy to regulate the use of seclusion and implement a protocol for its use to ensure patients' rights are upheld at all times.

Recommendation 4:
Managers should prioritise recruitment of clinical psychology staff and should consider all possible options to fill the post where applications are limited.

Recommendation 5:
Managers should ensure that, where a patient lacks capacity in relation to decisions about medical treatment s47 certificates, and where necessary, treatment plans must be completed and cover all relevant medical treatment the individual is receiving.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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