Mental Welfare Commission for Scotland

Report on unannounced visit to:

The State Hospital, Arran and Iona Hubs, 110 Lampits Road, Carstairs, Lanark, ML11 8RP

Date of visit: 20 February 2024

Where we visited

The State Hospital is the national high secure forensic hospital for individuals from Scotland and Northern Ireland. All individuals are under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995; they are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings.

The Commission visits the State Hospital at a minimum of once per year to give individuals, their relatives, and staff an opportunity to speak with us. The hospital comprises of four units (hubs), with either two or three wards in each. We last visited Arran Hub in September 2022, and carried out a separate visit to Iona hub in October 2022.

We wanted to follow up on the issues identified from previous visits, and on matters that have been brought to our attention since then. We also wanted to give individuals an opportunity to speak with us regarding their care and treatment, and to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

On our last visit, we made a recommendation regarding individuals' attendance at multidisciplinary team (MDT) meetings to ensure they have the opportunity to put forward their views and discuss their care. The response we received from the service was that steps were being taken to ensure participation and engagement with individuals and their relatives at CPA meetings. We further noted the difficulties with recruiting and retaining staff and recommended that steps should be taken to address these matters which were impacting on individual care. The service responded detailing the various actions taken to address recruitment and retention for the hospital.

The hubs since our last visit have adopted a new clinical care model. The Iona Hub has reduced from three to two wards with Iona 1 closing. Iona 2 and 3 are the identified intellectual disability (ID) wards which were redesigned to meet the needs of this group. On the day of our visit, we met with individuals in Iona 2 and 3, and those in Arran 1, 2 and 3. These hubs comprise of one admission/assessment ward and two treatment and recovery wards.

At the time of our visits there were 98 individuals in the hospital; there were 43 individuals in the Arran and Iona Hubs.

Who we met with

On the day of the visit, we met with the deputy chief executive as well as the charge nurses and the nursing staff on each of the wards we visited. We met with and undertook file reviews into the care and treatment of 14 individuals. We spoke with two relatives who wished to discuss the care and treatment offered to their relatives and the supports they receive from the hospital.

Commission visitors

Justin McNicholl, social work officer
Gemma Maguire, social work officer
Anne Buchanan, nursing officer
Claire Lamza, executive director (nursing)
Gordon McNelis, nursing officer

What people told us and what we found

Care, treatment, support and participation

As this visit was unannounced, individuals and staff were not prepared in advance. Despite this, we were given full access to the ward to meet with individuals and staff.

During our meetings with individuals, we discussed a range of topics that included contact with staff, individual's participation in their care and treatment, activities available to them and their views about the environment. We were also keen to hear from individuals who had been in the State Hospital for a number of years and those who were subject to excessive security appeals.

Individuals interviewed on the visit gave the commission visitors mainly positive comments about support provided by nursing staff, medical staff and the other professionals working in the hubs. This included "I get good help", "staff are really helpful", "they always listen", "being here has really benefited me" and "I don't think staff are praised enough for the work they do". Some individuals spoke of disagreeing with aspects of their care and treatment and how they felt listened to, but ignored. This included, "seems to be an old school attitude (staff) and I don't feel there is a lot of encouragement to progress", "there's a lack of intellectual disability nurses on the ward and I feel there should be more to support the patients" and "they do listen but don't do anything about what I have to say". Individuals spoke of having access to the hospital complaints procedure, legal representatives, the hospital advocacy service and were able to express their opinions at Care Programme Approach (CPA) meetings and with meetings that took place with their named nurses or psychiatrist.

We heard consistent views from all the individuals we spoke to in Iona 2 that they were "annoyed", "fed-up", "and "not sure how I will ever move on from here. There were themes in Iona 2 that individuals were not clear on what they needed to do to, or what actions they needed to make progress in, to be able to reduce their level of observations or obtain a transfer to another hospital. The level of frustration and unhappiness expressed by individuals in Iona 2 regarding their care was markedly different from the other wards we visited. We heard from senior managers that there was a planned internal review of the ID service, which they hope will benefit the individuals we spoke with. The frustrations of individuals were echoed by their relatives. We heard from them that "these wards need closing down" and "they have had my son for years and the care and treatment has made no difference to him. Instead it has only made him worse", highlighting that the current approach in Iona 2 in supporting the individuals, and their relatives, is not achieving the intended outcomes.

Compared to our last visits in 2021 and 2022 the theme of staffing pressures throughout the hospital was not raised by the individuals that we spoke with. We are aware that this remains a key factor for senior managers but it was positive to note that it not a theme that arose during this visit. In 2021, we were aware of the lack of staffing and ward closures resulting in confinement to their rooms for individuals throughout the day, and overnight. Confinement overnight remains in place in the hospital. Hospital managers have set up a new process mapping tool around the use of daytime confinement that Commission staff had sight of on the day of the visit. This new tool was found on the electronic patient information system, RIO and provides direct daily oversight of the frequency of confinement on all individuals. This

relies on staff updating data in relation to when confinement is used. We were able to see that there was a significant reduction in confinement across all the wards we visited. We found six hours of confinement across the hospital site over the last two weeks, which was noted to be a significant improvement compared to our last visit to Lewis and Mull Hubs in September 2023, when we met with the hospital managers to discuss the impact that daytime confinement was having on staff and individuals. The Commission noted that managers have agreed to update us on the reduction and planned eradication of this practice.

We found regular six-monthly CPA meetings were being held for all the hubs. Managers advised us that they ensure relatives were provided with the opportunity to express their views at CPA meetings. We believe that the views of the named person or nearest relative should be reviewed more frequently than this. We found detailed reports from all professionals providing input to individuals' treatment plans were prepared for the CPA meetings, which were easily found in well organised electronic personal files. Individuals spoke of having good access to psychological therapies via psychology staff and supportive strategies via either named nurse.

Several individuals told us how nursing staff encouraged their participation and involved them in discussions about their care and treatment. We heard from individuals about their CPA reviews, how their named nurse would discuss the nursing report that had been prepared for the review with them, and how they felt able to put their views across in these CPA meetings. There was also evidence of good input from advocacy services in the hospital. Several individuals spoke about meeting with an advocate regularly, and about the advocate attending reviews or assisting them in raising complaints where necessary.

We found a number of advance statements in the files we reviewed. There has been a strong emphasis in the Care Programme Approach on providing individuals with information about advance statements. We also saw evidence that staff were proactive in discussing advance statements with individuals, and in witnessing them following discussion.

Due to the unannounced nature of this visit we were unable to meet with psychology staff to discuss their role and oversight of the individuals they were working with. We did however view the various Historical, Clinical and Risk Management 20 **(**HCR -20) reports they had completed for each individual we reviewed. We found that these were completed to a high standard and the use of HCR-20's has been helpful in supporting individuals to move to a lower level of security, with clarity on the risks associated of each individual.

All of the staff members we spoke with knew the individuals in their care well and were able to comment on risk and their associated management plans. This was further reflected in the interactions we observed and the daily notes we read.

Care records

Information on individuals' care and treatment continues to be held on the fully integrated system, RIO. We found this to be responsive, easy to navigate, and it allowed all professionals to record their clinical contact in one place. Care records were detailed and comprehensive. The Hospital Electronic Prescribing Medicines Administration (HEPMA) system was in place across all wards.

Care plans

In 2021 and 2022, we found care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of individuals. For this visit, the care plans that we read were detailed and person-centred, all demonstrating clear evidence that they are evaluated regularly. It was positive to see discharge care plans in place, where appropriate, and there was evidence of regular review. We also found detailed information of one-to-one discussions between individuals and their named nurses.

Multidisciplinary team (MDT)

The wards that we visited held regular multidisciplinary team meetings (MDT), the service referred to these as clinical team meetings (CTM). We found these meetings to be well-structured, with decisions taken in a timely way, with all recordings detailed clearly and concisely. Each ward CTM was made up of nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff. It was clear from the thorough CTM meeting notes that all professionals involved in an individual's care and treatment were invited to attend the meetings and provide comprehensive updates on their involvement. During our last visit in 2022, we recommended that individuals should attend CTM discussions, as they expressed the wish to participate in the decisions taken regarding their care and treatment. Individual's attendance and contribution at the CTM would be similar with the majority of services we visit across Scotland. We were informed that individuals are met with before and after each CTM meeting by their keyworker, to ensure their views and requests could be discussed. During this visit we did not hear any further issues directly from individuals about not being able to attend the CTM, however we believe this matter should remain under review by managers to ensure that individuals can participate and engage with those who are making significant decisions regarding their care and treatment.

Individuals at the State Hospital have their care and progress reviewed using the enhanced CPA, which is a framework used to plan and co-ordinate mental health care and treatment. CPA was used for all individuals in the State Hospital; of the records we reviewed, the documentation was detailed, and we found evidence relating to individual's rights.

We saw physical health care needs were being addressed and followed up swiftly and appropriately, and all relevant physical health monitoring was in place. The point of access for individuals requiring urgent health care is through a contracted general practitioner, who visits the hospital twice a week. The GP service provides treatment of minor ailments, which reduces the number of times individuals have to leave the hospital to access secondary care.

Participation

During our announced visits to the State Hospital, we usually meet with the person-centred improvement lead for the Hospital. Since our last visit, the previous post holder has retired and the responsibilities from this role are now the remit of the Skye Centre manager who manages the person centred improvement team. We have been informed that the previous carers group has not been functioning but there are plans for this to be re-established in the coming months. Due to this being an unannounced visit, it was not possible to meet with anyone from the carers centre, however we aim to do so during our next announced visit. At a future date, the Commission would also plan to attend this group, so that we can gather

views or identify themes that may have an impact upon carers and relatives' experience of the hospital.

Use of mental health and incapacity legislation

Individuals at the State Hospital are subject to restrictions of high security; all individuals require to be detained either under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (CPSA). The individuals we met with during our visit had a clear understanding of their detained status. All individuals that we met with reported that they had access to advocacy support and legal representation.

All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place and were up-to-date. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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, where required, should correspond to the medication that is prescribed. All the forms that we reviewed were completed by the responsible medical officer (RMO) to record non-consent, and they were up-to-date. We found when reviewing the T2 and T3 certificates that previously expired certificates were stored alongside the current certificate in the individual's file. We suggest that managers ensure expired certificates are removed to avoid any risk of inaccurate medication being administered to individuals.

Recommendation 1:
Managers and medical staff should ensure that all expired T2 and T3 forms are stored appropriately.

Any individual who receives treatment under the Mental Health Act or Criminal Procedure Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this on the individual's record.

Where we found individuals were subject to a guardianship order under the AWI Act, staff had a clear understanding of these orders. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 found completed forms and a record of communication with families and proxy decision makers in all of the files that we reviewed.

When an individual is subject to a section 47 certificate we would expect to see a treatment plan, which is called an Annex 5 form. This is completed by the clinician with overall responsibility for the individual. The treatment plan should be written to include all of the healthcare interventions that are anticipated to be required during the time specified in the certificate. The treatment plan should be clear on whether the individual has capacity to make

decisions regarding nutrition, hygiene, skin care, vaccinations, eyesight, hearing, and oral hygiene. We found no treatment plans attached to the section 47 certificates that we reviewed.

Recommendation 2:
Medical staff should ensure that when a section 47 certificate is issued, a treatment plan is then completed.

Rights and restrictions

We were unable to meet with the advocacy staff for this visit. Despite this, individuals reported to us that they found the advocacy service to be very helpful, responsive to their needs and described it as "good" and "always available".

The visit report in 2022 commented upon the challenges for the hospital to access translators for individuals whose first language was not English; for this visit, there were no issues or concerns raised by staff or the individuals that we met with.

When we are reviewing individual records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 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 found copies of advance statements and clear recordings in individual files when they chose not to complete one.

The Commission has regularly highlighted the significant difficulties with regard to 'individual flow' across the forensic estate. The situation of individuals in the hospital awaiting a move to a lower level of security remains an issue that continues to be raised with Scottish Government and the Forensic Network in terms of a capacity review. The Commission has produced *Appeals against detentions in conditions of excessive security* good practice guidance which can be found here:
https://www.mwcscot.org.uk/node/1674

Bed capacity in the hubs was not an issue on the day of our visit. There does however continue to be a lack of beds in medium and low security forensic services across Scotland, which has also been raised with Scottish Government. As previously reported, the recommendations from the commissioned *Independent Review into the Delivery of Forensic Mental Health Services in Scotland*; the *What people told us* report, which was published in August 2020, is still under consideration by Scottish Government; the Commission will continue to monitor and contribute to this work.

The exact number of individuals awaiting moves to lower levels of security changes regularly. During our visit there were a number of individuals who were found to be in conditions of excessive security. Due to the wait for a lower level of security, some individuals have made an appeal to the Supreme Court, the appropriate legal route to escalate these matters. The Commission remains concerned that the rights of these individuals to move to be transferred are not being met, and we continue to follow up on individual cases, where appropriate.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals 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

Since our last visit, it was positive to note that individuals appear to have increased access to a range of recreational and therapeutic activities, particularly through the Skye Centre, which is adjacent to the hubs. We spoke to a number of individuals who commented, "I really enjoy the work at the Skye centre" and "I get to go seven days a week and they are great up there." We also heard some comments around access to the centre such as, "I don't get to go enough as there is demand for certain activities" and "I wish there was more flexibility".

In the hubs, it was calm with staff and individuals moving throughout the areas for various activities, meetings and grounds access. Many of the individuals presented as relaxed and comfortable with the staff on shift.

We are aware from previous visits that the hubs have multi-functional spaces which allow the wards to share a range of facilities for, group treatment/therapy facilities. These activity areas have exercise equipment and pool tables in place. Due to the Covid-19 pandemic, these activities were stopped. We heard from senior managers that there are steps being taken to re-open these spaces for individuals who may not be able to access the Skye centre or who would be interested in undertaking alternative activities. We look forward to seeing the impact of these spaces being re-opened when we next visit.

The physical environment

The physical environment of Arran and Iona Hubs was largely unchanged from previous visits to these hubs. The wards have single en-suite rooms, access to a secure garden area, and areas that support safe and secure care.

We were pleased to note that steps had been taken to risk assess and minimise harm to some of the most distressed individuals in the hospital. This includes the creation of a modified bedroom with reinforced soft walls, beds and furnishing. These adjustments have mitigated incidents of deliberate self-harm occurring in this space.

We heard from some individuals about the noise in the ward; they commented that "the ward can be noisy".

We found bedrooms across the wards were personalised and provided a comfortable and relaxing environment for the individuals with whom we met. We also found that some individuals were being nursed across two bedrooms as a means to reduce disruption when they were well enough to return to their bedrooms.

The hospital continues to have extensive grounds with walking trails; it remains a smoke-free environment. CCTV is currently in operation in the grounds of the hospital. There is no CCTV in the communal areas of the wards, however there is consideration of cameras being introduced into these areas in the future. The Commission would wish to be kept informed of any developments in this area.

Summary of recommendations

Recommendation 1:
Managers and medical staff should ensure that all expired T2 and T3 forms are stored appropriately.

Recommendation 2:
Medical staff should ensure that when a section 47 certificate is issued, a treatment plan it then completed.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan for responding to any recommendations.

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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