Mental Welfare Commission for Scotland

Report on announced visit to:
Lewis and Mull Hubs, the State Hospital, 110 Lampits Road, Carstairs, Lanark, ML11 8RP

Date of visit: 13 June 2024

Where we visited

The State Hospital is the national high secure forensic hospital for individuals from Scotland and Northern Ireland. Those being cared for in the hospital are subject to 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.

Of the hospital population, 75% are monitored by Scottish Ministers due to their restricted status. 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. Since our last visit, the hospital has continued to adopt a different clinical care model that has reduced Mull hub from three to two wards, with Mull 3 closing prior to our last visit to the hub.

On the day of our visit, we met with patients in Mull 1 and 2, and in Lewis 1, 2 and 3. These hubs comprise of one admission ward, two treatment and recovery wards and two transition wards. At the time of our visit there were 99 individuals in the hospital; 54 were in the wards in the Mull and Lewis hubs.

We last visited Arran and Iona in February 2024, as an unannounced visit. Our last visit to Lewis and Mull hubs was in September 2023. 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 patients 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.

During our last visit we made recommendations regarding staffing levels in the hubs, individuals and relatives views being captured at multidisciplinary team meetings and that all treatment was legally authorised and on the correct paperwork. We further recommended that steps should be taken to address staff training and the promotion of advance statements.

Who we met with

Prior to the visit, we held virtual meetings with the director of nursing, the associate medical director, the associate nurse director, the social work manager and the advocacy manager. On the day of the visit, we met with 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 12 individuals. We carried out a further nine file reviews into individuals' care and treatment.

On the day of the visit, we met with the music therapist, the head of psychology, and members of the psychology team.

Commission visitors

Justin McNicholl, social work officer

Gemma Maguire, social work officer

Lesley Paterson, senior manager (east team)

Anne Craig, social work officer

Anne Buchanan, nursing officer

Paul Macquire, nursing officer

Kathleen Taylor, engagement and participation team manager

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included their legal status, contact with staff, individual 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 short period of time to understand how they were being supported with the transition to a high secure hospital.

Individuals that we spoke with were very positive regarding the use of the current clinical model. We heard comments such as “they have the right people in the right places”. This view was echoed by the staff we spoke with saying “the new arrangement is much better for the majority of the patients; it is helping to support better communication.” We were told that “the model ensures in-reach for patients which is a significant benefit, with great support for those who are most unwell and who cannot attend the Skye Centre”.

We heard from some staff that the clinical model was “not running as well as it could be, due to issues with patient flow across the hubs”. There remained an acknowledgement from individuals and staff that the move of individuals to medium secure hospitals was not consistent across Scotland, with certain hospitals not willing to accept people for a variety of reasons. This then resulted in challenges with the delivery of the clinical model for those who have been in the hospital the longest.

Staff and managers hope that the creation of a new forensic mental health board for Scotland may help to improve consistency across the estate, would ensure that individuals are closer to their home area and could minimise unnecessary delays for individuals in the hospital, as highlighted in the Independent Review into the Delivery of Forensic Mental Health Services (2021).

Since our last visits in 2023 and 2024, the staffing pressures throughout the hospital remain a key factor that has had an impact on the care and treatment of some of the individuals we spoke with. We heard from managers that when individuals have required to be transferred to other hospitals for non-mental health related treatment, the demands on staffing, due to the number of staff required to take individuals out of the hospital, are high. This demand then has a significant impact on individuals’ access out of the hubs around the hospital.

The use of confinement during the day and overnight remains an issue for everyone we spoke with. Overnight confinement was introduced to the hospital in 2011 and has remained a consistent part of practice since then. Daytime confinement has been introduced since the Covid-19 pandemic and has been linked with staffing shortages. We commented previously on the use of daytime confinement (DTC) during our visits in 2022 and 2023. The hospital managers have a process mapping

tool that Commission staff had sight of on the day of the visit. The tool is on the electronic patient information system, RIO which provides a daily overview of the frequency of confinement on all individuals. This system relies on staff inputting when confinement is used with the lead nurse and director for approval. This is further monitored by the completion of a DATIX report for each individual who is subject to these measures.

For this visit, we noted that across the previous seven-day period, the use of DTC totalled 35 hours for all the hubs. This was a significant reduction compared to the highest level of DTC occurring for 487 hours for one week in May 2024. This spike in DTC was due to the number of individuals requiring treatment in other hospitals and was not a reflection on the average use of confinement across the last three months. The use of DTC remains a cause for concern for the Commission.

We did not hear from any individuals who were concerned; instead those that we spoke with appeared to understand the pressures on the staff. Many staff noted their frustration at the use of DTC practice; staff remained hopeful that the use of DTC would improve. Managers acknowledged that there were plans in place to reduce the frequency of DTC by employing new nursing staff and recruiting additional health care assistants. Managers remain optimistic that with their recruitment drive and the retention of staff, the use of DTC over the coming year should reduce. When we next visit the hospital, we look forward to seeing whether the steps taken by the hospital have eradicated the occurrence of this practice.

We heard from staff and individuals that the “room for you” was being used as a means to manage individual requests for voluntary time in their own rooms. These requests, according to both staff and individuals, were frequent as it allowed individuals the space to watch television, read, listen to music or relax away from the busy environments in the day areas. We acknowledged that using the “room for you” is different from the requirement to use DTC where individuals have no choice or say with these restrictions.

We heard from those that we spoke with, that staff were “approachable”, that the care was “very good” and that “staff look out for you and they are helpful”. We were told that “staff can’t do enough”, “they always help and are caring” with one person telling us that “this is my home”.

Similar to our visits in 2022 and 2023, many individuals told us that they felt “protected” in the hospital compared to their time in other institutions i.e. prison. Many stated that they felt “safe” due to the support of staff and the overall structure of the hospital. We heard further comments that staff consistently engaged with individuals before and after the ward multidisciplinary team meeting. This ensured that individuals were supported to put forward their views and to raise any issues they had.

We heard positive feedback from individuals that steps had been taken to improve the quality of food in the hospital. One individual noted, “they have replaced processed chicken with real chicken” which was a positive example of staff listening to individuals and acting on their views.

We were given positive examples of the work undertaken by psychiatry staff. One individual stated, “the doctor pushed to get me moved onto medium security as I don’t need to be in a high secure hospital any longer”, whilst another stated, “the doctor is great…me and my family are kept updated”. All of the staff members we spoke with knew the individuals well and were able to comment on levels of care, enhanced observations, restrictions, risks and any future plans. This was further evidenced in the interactions we observed and the detailed daily notes we read.

During our last visit we heard about the appointment of the new head of psychology for the hospital. On this occasion, we took the opportunity to meet with her and members of the team to discuss the service being provided by the team. The meeting provided an oversight of the specific remits of the core psychology team who cover the four hubs of the hospital. The psychology team is made up of 33 members of staff that includes forensic clinical psychologists, principal clinical psychologists, clinical psychologists, assistant psychologists, nurse therapists, a health psychologist, specialist nurse practitioners, and four link nurses.

The role of the link nurse has developed in that nursing staff are seconded to the psychology service one day per week. These nurses focus on the goals, interventions and strategies recommended by psychology staff which helps to aid with a consistent approach to care and recovery. The Commission found this to be a significant asset to the service and we heard positive feedback about this role, particularly from staff that we met.

The positive role of the current psychology team in the hospital appears to support individualised treatment that benefits those who can access this service. The psychology staff continue to have a key role in the completion of the majority of the Historical, Clinical and Risk Management-20 (HCR -20) reports. We found that these were completed to a high standard and along with the use of HCR-20’s, as well as the Risk of Sexual Violence Protocol report, assists with the transfer of individuals moving to a lower level of security when deemed appropriate.

During this visit we met with one of the music therapists for the hospital. We had received positive feedback from staff regarding their role, with a specific focus on the delivery of this therapeutic treatment that focused on recovery goals. The music therapist praised the multidisciplinary staff and the ability of nursing, psychiatry, occupational therapy and other disciplines to demonstrate trauma informed practice on a daily basis. We noted that joint work with the music therapist and the nursing

staff had been able to deliver positive outcomes for some of the most unwell individuals in the wards, who were subject to high levels of enhanced observations.

Our visit had been promoted to the carers group based in the hospital, and included posters and telephone prompts, although no carers wished to speak with us on the day of the visit.

Care, treatment, support and participation

Nursing care plans

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

We found that individuals in the hospital had care and treatment plans in place to support admission goals, outcomes and identified plans of nursing care. These were stored on the RIO electronic recording system. In our previous visits, we had no concerns with the quality of the care plans; we found them to be comprehensive, with a clear focus on risks. We were pleased that this continued to be the case for this visit.

In our review of the care plans, we noted that individuals in the hospital had a wide range of complex mental and physical health needs. We found that individuals had multiple plans to support all aspects of their care and treatment in the hospital. The information in these plans comprehensively detailed the care, treatment and support the individual required, providing a clear understanding to staff as to what nursing intervention was necessary to provide the support required. The information was person-centred, with a focus on recovery towards discharge.

We saw evidence of reviews of the care and treatment plans, with the majority of the reviews being sufficient, and providing a summative evaluation of the individual's progress. In the State Hospital there is an expectation that all care plans are reviewed monthly. We found inconsistencies with this target being achieved. Many of the care plans were not being reviewed in line with the hospital standard. We discussed this matter with managers who agreed that it needed to be addressed.

Recommendation 1:
Care plan reviews should be completed on a consistent basis by nursing staff in line with the hospital target.

We found limited evidence that individuals were fully involved in the completion of the care plans although the views of the individuals were taken into account. We found no clear evidence that named persons, relatives/carers had input into the care and treatment plans devised and their views were not reflected.

Recommendation 2:
Care plans should be completed to ensure engagement with individuals, their named persons and relatives and that these views are reflected in the care plans.

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.

Participation
As highlighted in our report in 2023, we wanted to get more information about the patient participation group (PPG). This is a group of individuals, who are representatives for the ward they are based in; the PPG chair is elected by their peers. This appears to be working well and ensures participation. The group meets weekly to consider any issues, concerns, or suggestions they have. There are then regular community meetings that take place on each ward. The PPG meetings were minuted and allowed all individuals to discuss issues and make suggestions that related to their particular ward.

We heard from senior managers that the Skye Centre continues to provide a space outwith the hubs for individuals to link in with the advocacy service; this service supports those who may wish to raise complaints or matters that have not been dealt with at ward level. We found the ease of access to advocacy and the PPG were positive measures and ensured that participation was being promoted by the hospital. During our routine visits to the State Hospital, we usually meet with the person-centred improvement lead for the Hospital, however that was not possible during this visit. We aim to meet with the lead during our next visit.

The forensic network is working on the design of a toolkit which aims to help carers and relatives on what services and supports are available. This should serve to signpost relatives who find themselves visiting their relatives in the unique environment of the State Hospital. We look forward to hearing how this toolkit will improve the experiences of relatives/carers in the coming years.

Care records
Information on individuals' care and treatment continued to be held on the fully integrated electronic 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. From the records we accessed, recordings on this were found to be clear and accurate.

Multidisciplinary team (MDT)
The wards that we visited held regular multidisciplinary team (MDT) meetings, which the service refers to 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 includes nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff. It was not always clear from the CTM meeting notes who was in attendance at the meeting when recorded on the RIO system which we consider to be important when reviewing any significant decisions that are made regarding an individuals' care and treatment.

The CTM notes highlighted the commitment to adopting a holistic and recovery-based approach. During our last visits in 2022 and 2023, we recommended that individuals should attend MDT discussions, so that they could contribute to the decisions about their ongoing care and treatment. The hospital position remains that this arrangement cannot be facilitated. Despite this, we found evidence that individuals were met with before and after each meeting by their keyworker to ensure their views and requests could be discussed at the MDT.

We continued to find limited evidence of relative or carer involvement pre or post MDT meetings. Managers advised us that they ensure relatives are provided with the opportunity to express their views at care programme approach (CPA) meetings, with most of these meetings taking place on a six-monthly basis. We did not hear from relatives or carers as to whether these arrangements had an impact on them obtaining regular updates. One individual that we spoke with wished to attend the CTM discussions, to participate in, and influence the decisions taken regarding their care and treatment. We believe that the lack of attendance by individuals at the CTM should remain under review by managers as it would ensure meaningful participation and engagement.

Individuals at the State Hospital have their care and progress reviewed using 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 individuals' 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 a number of primary care functions which includes the treatment of minor ailments, which reduces the number of times individuals have to leave the hospital to access secondary care.

In discussions with staff, we heard from each hub that we visited that there were positive team formulation discussions which helped to address individuals' circumstances; this was evidenced by the care plans and recordings that we read.

Recommendation 3:
Managers should ensure that all clinical team meetings held record who is in attendance.

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 (Criminal Procedure Act). The individuals we met with during our visit had a clear understanding of their detained status. All individuals that we spoke with had 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. Where appropriate, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act, should correspond to the medication that is prescribed. All forms that we read, apart from one, were found to be in order. The rest of the forms that we reviewed were completed by the responsible medical officer (RMO) to record non-consent, and they were up-to-date.

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 individuals were subject to a guardianship order under the AWI Act, staff had a clear understanding of these orders.

Rights and restrictions

Several of the individuals we met with were subject to enhanced levels of observation. Some of these individuals were being nursed in their bedrooms for the safety of themselves or others. All the observations that we witnessed on the day of our visit were being delivered to a suitable standard and in line with good practice.

It was noted that for those individuals who were subject to enhanced levels of observations, due to difficulties with their mental state, they could only leave their

bedrooms once per day, as staffing shortages had an impact on their ability to get out of their rooms. This remains under review by managers due to the ongoing issue of staffing levels, similar the concerns with the use of daytime confinement.

Advocacy in the State Hospital is delivered by the Patient Advocacy Service (PAS). Individuals reported to us that they found the advocacy service to be very helpful, responsive to their needs and described it as "very supportive". We met with the advocacy service and heard that it was a well-used and valued service. Since our last visit, the advocacy provider has been awarded a contract to serve the hospital for a further three years, which provides stability to individuals and staff who have close working relationships with the advocacy staff.

It was noted that of the 99 patients in the State Hospital, all of them have regular input from the advocacy service. We heard that advocacy staff prior to our visit had been experiencing some difficulties with accessing individuals prior to lunchtime, however when we spoke to them during our visit, access issues had been resolved.

We found that the advocacy service continues to work closely with the hospital complaints officer. Advocacy also continued to liaise with senior members of staff and had input into the induction programme for new staff. We were advised of the ongoing protocol that ensures that there is consistent advocacy cover for those individuals who are boarding out in a general hospital. We saw from a review of the care records that advocacy attended the ward regularly and supported individuals who were involved in tribunals, discharge planning and CPA meetings.

When we are reviewing an individual's 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. On this visit we found advance statements were in place, where appropriate.

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 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, are still under consideration by Scottish Government; the Commission will continue to monitor and contribute to this work.

The exact number of individuals waiting to move to a lower level 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 had appealed to the Supreme Court, the appropriate legal route to

escalate these matters. The Commission remains concerned that the rights of these individuals to move are not being met, and we will continue to follow up on individual cases, as appropriate.

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 moves to lower levels of security remains an issue that continues to be addressed by 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*.

We heard from management of plans in the coming year to introduce closed circuit television (CCTV) cameras across all hubs in the State Hospital. These will be located in all communal areas of the wards but not in individual bedrooms unless individuals are being nursed in the modified strong room (MSR). When we visit other hospitals across Scotland, where the use of CCTV cameras is in place, we have received feedback from individuals and staff in these settings of the benefit of these cameras to address any allegations of harm and to support a quick response in investigating incidents that provides protection of all. When we next visit the hospital, we will review the impact of the introduction of CCTV, and any issues there may be in relation to safeguarding and protecting an individual's privacy and dignity, as well as safeguarding the most vulnerable.

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.

Activity and occupation

The majority of individuals continue to have regular access to a range of recreational and therapeutic activities, particularly through the Skye Centre, which is adjacent to the hubs. During the visit, we found the hubs to be 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 were aware from previous visits that the hubs have multi-functional spaces that 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.

We heard from individuals that these areas were not being used and that they were disappointed with this as they would like to play pool. We agreed to highlight this with senior managers. We heard from the senior managers that a pilot project had been undertaken to increase the use of the multi-functional spaces for individuals.

To date, this pilot has not been successful in increasing the use of the multi-functional spaces by individuals as most wish to access the Skye Centre or are more interested in undertaking alternative activities. Management agreed to look into the use of the multi-functional space again for the benefit of individuals in the hubs.

The physical environment

The physical environment of Lewis and Mull hubs was unchanged from previous visit. The wards have single en-suite bedrooms, access to a secure garden area, and areas that support safe and secure care.

During this visit we found the wards to be clean and tidy. We did however note that many of the walls in the day rooms and nurses' stations required painting. Several of the walls had old sticker marks on them as well as paint that had cracked. We did not think that this would be welcoming for new individuals arriving in the ward.

Recommendation 4:
Management should ensure the timely redecoration of the wards to ensure the environment remain welcoming and fresh for both individuals being cared for in the hospital and staff.

We received feedback from a number of individuals who have been transferred to the State hospital from prison. Many of these individuals would normally have had regular access to a television in their prison cells prior to moving into the hospital. The State Hospital does not provide televisions for individuals, and mostly people will purchase their own via their own funds. Those individuals subject to transfer for treatment directives (TTDs) only receive limited funds due to their status. As a result of this these individuals cannot afford to purchase televisions which they then cannot take with them upon their return to prison. Individuals noted their frustration at these circumstances, and wished to highlight that access to televisions was not equitable. Individuals spoke of how they had raised this with the PPG group and were disappointed that nothing had been done to address these matters. We fed this back to hospital managers and asked that they look into this matter further.

We observed whilst walking in the grounds of the hospital that the areas outside and adjacent to the hubs were overgrown with weeds. We highlighted this to managers who agreed this matter would be addressed.

We received positive feedback regarding the family centre, which is used for contact between individuals and their relatives. An example of the type of comment we heard was, "it's a really nice place to be".

Summary of recommendations

Recommendation 1:
Care plan reviews should be completed on a consistent basis by nursing staff in line with the hospital target

Recommendation 2:
Care plans should be completed to ensure engagement with individuals, their named persons and relatives and that these views are reflected in the care plans.

Recommendation 3:
Managers should ensure that all clinical team meetings held record who is in attendance.

Recommendation 4:
Management should ensure the timely redecoration of the wards to ensure the environment remain welcoming and fresh for both individuals being cared for in the hospital and staff.

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.

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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