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: 29 August 2024

Where we visited

Gigha Ward is a 12-bedded mixed-sex forensic rehabilitation unit on the purpose-built Beckford Lodge site. The ward provides a step down from the low secure forensic wards.

On the day of our visit there were 12 individuals on the ward.

Iona Ward is 15-bedded, purpose-built, low secure forensic mental health ward providing care and treatment for male forensic patients across NHS Lanarkshire.

Individuals from both wards can access Caird House which is on the Beckford Lodge grounds; they have access to the large kitchen for group work, a large outdoor garden area with access to gardening activities, outdoor seating, and access to a bicycle maintenance shed. There is a studio in the grounds of Caird House for art project work with individuals.

We last visited this service in January 2023 and made recommendations regarding a consistent recording system across both wards, consistent recording of care plans reviews, consistent recording of multi-disciplinary team (MDT) meetings on patient participation in care plan reviews and that all forms for consent to treatment were up-to-date with prescribed medication. The response we received from the service was that these recommendations had been addressed. On the day of this visit we wanted to follow up on the previous recommendations and hear from individuals and staff about how the service was managing with the demand for low secure placements.

Who we met with

We met with and reviewed the care of nine people.

We spoke with the charge nurses for the wards and other clinical staff including one of the consultant psychiatrists and the one of the occupational therapists.

Commission visitors

Justin McNicholl, social work officer

Mary Hattie, nursing officer

Andrew Jarvie, engagement and participation officer

What people told us and what we found

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

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 Beckford Lodge for a short period of time to understand how they were being supported with the transition to a low secure hospital.

Individuals that we spoke with were very positive regarding the care they were receiving from all staff. We heard comments such as “the staff are very good”, “they want to get it right for you” and “it’s the best care I’ve ever had”.

We observed positive and empathetic care being delivered to the individuals in both wards. There were views shared by both staff and individuals that the wards can be “busy” and “noisy”, particularly Iona Ward who tends to have individuals who have less time off the ward and has not yet progressed to obtaining their own tenancies in the community. The ward team noted that at times, they can be short-staffed, due to a variety of reasons. This was the case on the day of our visit. Despite this, we heard from both individuals and staff that this did not significantly impact upon the care being delivered.

In both wards we heard comments about the food on offer. The feedback was positive with most commenting that there was “a good variety of choices” and “you can always get something you want”. We heard from individuals that they were encouraged to make their own meals in Gigha Ward and had access to a kitchen, pantry, cupboard space, and fridge to make their preferred meals. We observed staff working with individuals to prepare their meals to their specific preferences. We found that those individuals observed took much joy in being able to complete these tasks with staff demonstrating respect, dignity and empowerment.

There was clear evidence that the staff knew all the individuals well, with a clear and consistent understanding of their risks and how to manage these accordingly in the confinements of a low secure ward.

All the individuals that we spoke to had access to mental health officers, lawyers, and advocacy staff as and when required. Many spoke of the ease of accessing all of these external professionals.

We discussed with individuals their contact with psychiatry, psychology and allied health professional staff. The comments we heard included, “very approachable, especially if I have any questions”, “if it wasn’t for the time taken by the occupational

therapist (OT) to work with me I wouldn't have the skills to cook my own meals" and "they always have the time to listen and give advice which makes me think again".

In both wards, where individuals had discharge plans in place, they were aware of these. We were advised of one individual whose discharge from hospital was delayed and discussed this further with staff in relation to the steps taken to address this individual's circumstances and to speed up their discharge. Of the 12 individuals in Gigha Ward, four had new tenancies in place, ready for their planned discharge and were out on pass during this visit. There is a delayed discharge team in place who become involved in the discharge process. When required, the team holds regular meetings between ward managers, housing and social work services.

From the files we examined, all individuals were managed under the care programme approach (CPA), with regular meetings for individuals and relatives/carers, and where individuals were in agreement, they were invited to attend the meetings. Individuals from both wards told us that they were aware of their CPA meetings and the plans associated with these.

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 who they are working with. We did however review the various Historical, Clinical and Risk Management 20 (HCR -20) reports they, or their colleagues in other hospitals, had completed for each individual we reviewed. We found that these were completed to a high standard and the use of HCR-20's had assisted the hospital to support individuals moving to a lower level of security, with clarity on the risks associated with all individuals.

Individuals in Iona and Gigha had access to their own en-suite bedrooms that were modern and bright. We heard some comments from individuals in Gigha Ward that the first floor where the bedrooms are located can be "very warm" depending upon the time of year. We heard from staff of the steps taken to minimise any discomfort to individuals, with regular liaison with staff in the estates department to turn up or down the heating system depending upon the season. The issue with the heating was reported to be due to the design of the building and how it was insulated when built. The majority of individuals raised no issues regarding this matter and spoke of how it made no difference to their ability to sleep or feel comfortable in their bedrooms.

Care, treatment, support and participation

Nursing care plans are a tool that set out how care should be delivered; best practice would be for effective care plans to be in place, to provide consistency and continuity of care and treatment. They should also be regularly reviewed to provide a record of progress that has been made.

We would expect to find care plan reviews that provided a good level of detail on the progress that had been made and that identified areas of care that required ongoing support. These would include information about the specific nursing interventions and the individuals' progress in relation to the goals set. We found evidence of care plans in place across both wards, however these were not found to be personalised and did not reflect individual circumstances.

We found care plan reviews taking place in Gigha Ward but similar to our last visit, we could not locate the reviews for individuals on Iona Ward.

Recommendation 1:
Managers should carry out an audit of the nursing care plans to ensure they personalised and reflect individuals' circumstances.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they are being completed and address goals identified in the care plans consistently across both wards.

Risk assessments in both wards were easy to find, comprehensive, of a good standard and regularly reviewed.

We heard from nursing staff that they regularly signpost and support individuals, relative and carers to local services which included Lanarkshire Links. Work had started with the occupational therapy staff to engage and support carers who had relatives in the wards.

Nursing staff advised that following a successful recruitment process, they would soon be fully staffed across both wards, with the employment of a newly qualified nurse who was starting in the coming week.

Care records
We were pleased to see that notes in the care records were from various members of the multidisciplinary team. In particular, the care records from occupational therapy staff were of a high standard. We were pleased to find regular review of individuals' mental health by the consultant psychiatrists. The care records we reviewed were thorough. We found that the multidisciplinary team across the wards were actively involved in providing the support, care and treatment to individuals throughout their journey.

In Iona Ward, all information relating to care was held in paper files. When we last visited, we recommended that Iona Ward moved to the electronic record system in line with the rest of the mental health services. We were advised by managers on the day of our visit that there is a plan for this to occur in the coming year; we look forward to seeing during our next visit.

Gigha Ward notes were held in three different locations, on the electronic record system MORSE, on paper files, and in a shared folder system. Due to the number of locations that records are held, it was not easy for Commission staff to navigate and locate information. Due to this, we would question whether this is a safe route to access individuals' records. In line with our previous visit, we remain concerned about the lack of continuity in the recording systems across the wards.

Recommendation 3:
Managers should urgently address the issue of electronic and paper patient record systems to ensure all information relating to individuals is easily located and accessible.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)
The multidisciplinary team (MDT) meeting was held weekly. In attendance at the meetings were medical, nursing, psychology staff, junior doctors, occupational therapy, pharmacy, social work, and community support providers by invitation.

Individuals were given the opportunity to attend, however most did not wish to as they were able to meet with their named doctor on a regular basis to ask questions about their progress or their discharge plans.

The records identified the names of those at each meeting, so it was clear to tell who attended.

The MDT meeting had a detailed recording of the discussion and decisions that had been taken and we found they promoted a holistic approach to each individuals' care.

In some of the files we reviewed, there was evidence of discharge planning. For those individuals, there had been communication with community teams and services to support discharge planning.

There was a dedicated clinical psychology service based in the wards, and we heard positive comments from individuals about the support that had been provided. We found, and heard, of the benefit from regular OT involvement across the wards in relation to developing cooking skills and having access to a therapy kitchen in the wards. In relation to carer/relative involvement, we heard and saw that when family were involved with someone's care, separate family meetings were arranged.

[1] Person centred care plans good practice guide: https://www.mwcscot.org.uk/node/1203

Use of mental health and incapacity legislation

Similar to our last unannounced visit, we found all legal documentation to be in order and easy to access on both wards. On the day of our visit, all of the individuals in the wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act) as we would expect in the restrictive environment of a low secure setting.

We found all consent to treatment forms were in place as required 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, however we found a number of errors and discrepancies in both T2 and T3 forms that required addressing urgently by the medical staff; we discussed this with them on the day. The remaining T2s and T3s had been completed by the responsible medical officers available and up-to-date.

Recommendation 4:
Managers and medical staff should ensure that all consent certificates and certificates authorising treatment are up-to-date with prescribed medication.

Any individual who receives treatment under the Mental Health 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 in the individual's file.

Rights and restrictions

The main door to Gigha Ward is unlocked and individuals can come and go freely. In Iona Ward, the main 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 was one individual who was on an enhanced level of observations, however we did not find any recording or reviews of this level of enhanced observation in the individual's care record. We discussed this with the manager who agreed to address this.

Recommendation 5:
Managers should ensure that all enhanced levels of observations are recorded and reviewed in care records.

The unit does not use seclusion to manage any individuals experiencing stress or distress.

All those we met with had good knowledge of their rights.

We heard from managers that there are regular joint risk review meetings that take place to review individuals' rights, risks and restrictions. There is closed-circuit television (CCTV) used in the grounds of the hospital to monitor the hospital and to safeguard visitors, staff and patients.

All individuals on Iona Ward continue to be individually designated as 'specified persons' in relation to safety and security provisions, whilst individuals in Gigha Ward were made subject to specified person status on a case-by-case basis.

When we are reviewing individual files, 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 noted that in these were in place in some files and encouraged staff to discuss the use of advance statements more frequently with patients as their mental health improved.

The Commission has developed Rights in Mind[2]. This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We heard, and found, evidence of a broad range of activities that were available in the wards. Activity and occupation in the wards were mainly provided by occupational therapy staff. The variety of activities available to individuals in the wards included biking and walking groups, access to a games room, pool, darts, football, books, movie nights, iPad, gym and televisions. We heard of plans to introduce outdoor gym equipment when the garden area is upgraded in the coming year, which would be a valuable addition to the current provision.

For those with access to the community, they were able to attend various activities as arranged by the occupational therapy staff who facilitate Branching Out, access to Caird House that meets the specific interests of those in the ward.

We met with one of the occupational therapists for the wards. We heard that there has been a gap in occupational therapy provision to the ward due to maternity leave

[2] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

and vacancies. We also saw good evidence of the support for those individuals with neurodiversity in the forensic setting.

The physical environment

The physical environment is unchanged from previous visits. The décor in the wards was in good order.

Gigha Ward has single bedrooms, all with en-suite bedrooms. There are two bedrooms in the ward which are specially adapted to support those with physical disabilities. Individuals are encouraged to personalise their rooms. The unit has four lounge areas, activity space, assessment kitchens, and laundry facilities for individual use.

Iona Ward has 15 en-suite bedrooms, and again, individuals are encouraged to personalise their own space. The ward has an activity area, three lounges, and a gym for patients to use.

On the first floor of Gigha Ward there is a quiet room which staff use to undertake therapies with patients and when not in use, this area can be used by patients to relax.

There is enclosed outside space that patients can access directly from the ward. The outdoor space was in a poor state of repair although we heard that there are plans to redecorate this area with funds identified by managers.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plans to ensure they personalised and reflect individuals' circumstances.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they are being completed and address goals identified in the care plans consistently across both wards.

Recommendation 3:
Managers should urgently address the issue of electronic and paper patient record systems to ensure all information relating to individuals is easily located and accessible.

Recommendation 4:
Managers and medical staff should ensure that all consent certificates and certificates authorising treatment are up-to-date with prescribed medication.

Recommendation 5:
Managers should ensure that all enhanced levels of observations are recorded and reviewed in care records.

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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