



Mental Welfare Commission for Scotland

Report on announced visit to: Willows Unit, New Craigs Hospital, Leachkin Road, Inverness IV3 8NP

Date of visit: 7 December 2016

Where we visited

The Willows Unit is a six bedded learning disability assessment and treatment unit. It had six individuals in the unit on the day of our visit and another individual from the Willows Unit detained in Affric Intensive Psychiatric Care Unit. We last visited this service on 3 February 2016 and made recommendations on the availability of clinical nurse leadership for the ward, consent to treatment authorisation and the need for a 'use of seclusion' policy.

On the day of this visit we wanted to follow up on the previous recommendations and also look at delayed discharge from the unit. This is because we have learnt that a number of patients have still not progressed from the unit and this is having a significant impact on the learning disability service as a whole.

Who we met with

We met with and/or reviewed the care and treatment of five patients. No carers, relatives or friends were available to see us on the day of our visit.

We spoke with the hospital manager, the senior charge nurse and several other nurses throughout the course of our visit.

In addition we met with two advocates who were supporting patients.

Commission visitors

Tony Jevon, Social Work Officer

Susan Tait, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

There was a good record of multidisciplinary team meetings, including who attended.

Although there was very good input for physical health concerns from the GP for one individual who had significant health problems, there were no care plans to support this.

Patients seen were on the whole very happy with the care and treatment received in the Willows Unit and told us they were treated with respect by doctors and nursing staff.

There was good information available in an easy read format for patients to read on admission to the ward.

Some patients had a 'My Views and Concerns' form to record this information on their files, but there was little information on their background and social or family life.

Recommendation 1:

The senior charge nurse should ensure that a form that includes information about the social circumstances of the individual is completed as far as possible and held with the person's notes so it is readily accessible to all staff working with that individual.

There was a patients' forum led by advocacy and we saw good input from advocacy on the day of our visit.

Assessment and care plans

We found good evidence of a psychologist being used to complete assessments and provide advice and input into care planning. Most of the patients are on the multidisciplinary care programme approach, and there was evidence of regular care programme approach (CPA) meetings attended by professionals from a range of disciplines.

The care plans had no accompanying nursing assessments in the files so it was difficult to evidence how the needs identified had been arrived at. However, the care plans were more reflective of multidisciplinary input than had been previously noted.

We found that a generic mental health care plan was in use, which gave good pointers for consideration within a care plan, but often had not been individualised.

There was some rich information in the plans with clear care actions. However in some cases the level of detail was so in-depth that it may be difficult for nursing staff to follow and carry out.

Care plans were reviewed, but on an *ad hoc* basis rather than regularly.

There are no accessible easy read versions of care plans which we believe would help to involve patients in their own care planning.

Recommendation 2:

The senior charge nurse should review care plans to ensure that they are individualised and streamlined to aid 'usability'. Where appropriate, accessible plans should be developed to aid patient input into their care planning.

Use of mental health and incapacity legislation

Since our last visit a ward clerk has been given designated hours every week in the unit and this has helped with administration issues.

Five of the patients are currently detained and we looked at all of the Mental Health Act (Care and Treatment) (Scotland) Act 2003 (MHA) paperwork. No concerns were identified.

Adults with Incapacity (Scotland) Act 2000(AWI) s47 consent to treatment authorisations were also in order, along with accompanying treatment plans.

Rights and restrictions

Locked door policy

There is a locked door policy in place at the front door. However this is not in an easy read format for patients.

Recommendation 3:

Managers should develop a locked door policy in an easy read format for patients.

Seclusion

Seclusion has been used on more than one occasion, though not recently, and not since we last made a recommendation about this in February 2016. A draft policy has been devised but has not been implemented. Because of the low use of seclusion the hospital manager does not believe a policy is necessary, and in discussion with the Commission has expressed concern that it might lead to an increase in the use of seclusion. However we are concerned that, without a policy, patients' rights may be at risk when seclusion is used, even if this is rare.

Recommendation 4:

In order to protect patients' rights the hospital manager should introduce a 'use of seclusion' policy in line with the Commission's guidelines.

Specified persons

One individual seen, who was subject to random drug screening, had not been designated a specified person. This resulted in the individual's rights being breached. We asked that the appropriate authorisation for random drug screening is completed.

We were advised that training on this section of the MHA had been started but not yet been completed.

Recommendation 5:

The hospital manager should arrange for the completion of training in specified persons regulations for nursing and medical staff as soon as possible.

Activity and occupation

Whilst it was not raised as an issue by the individuals seen, we noted there is very little formal therapeutic activity taking place and we were told by nursing staff that it would be difficult to plan this in an achievable manner due to the demands on nursing staff time in the unit.

However, we were told by the hospital manager that following recent discussion with occupational therapy (OT) colleagues a 0.5 whole time equivalent OT and a 0.5 whole time equivalent OT technician will be devising plans to increase therapy input and will be delivering this as part of the learning disability team.

The physical environment

There are removable curtains on the outside of the bedroom windows, which provide some privacy. However they are easily opened by anyone from the corridor.

Recommendation 6:

The hospital manager should ensure the provision of curtains on the inside of the rooms, which can be removed if observation is required. This ensures privacy is managed by the patient where appropriate.

For clinical reasons access to fresh water is only available if asked for by the patients.

Recommendation 7:

The senior charge nurse should ensure that patients have easy access to drinking water.

Any other comments

We were pleased to hear that, regarding the availability of clinical nurse leadership for the unit, there is now an acting lead nurse within the service, with plans to progress this further once a management development course has been completed.

Delayed discharge

Half of the patients on the ward (n3) are formally considered to be delayed discharges. The patients we spoke to told us communication from the social workers, or the complex care team overseeing progress towards discharge, is poor and causes anxiety. One patient told us she cries at night because she is so unhappy about still being on the ward, despite being ready for discharge.

Because there are few vacancies in the Willows Unit vulnerable patients with a learning disability are sometimes placed inappropriately in adult acute wards in emergency situations. Others continue to be cared for in the community when it has been assessed that this is not the safest thing for them.

We heard from nursing staff that the frustration felt by patients can lead to distressed behaviour. In one case there was a recorded matter made a patient's delayed discharge by the Mental Health Review Tribunal, which had not been met. We explained to nursing staff that the patient's responsible medical officer (RMO) would need to notify the Tribunal in this case.

The consultant psychiatrist said that many people have had compromises in their medical treatment in an attempt to best manage the vulnerabilities and risks, but the learning disability service has endeavoured to ensure that the patients who have higher severity of learning disability and the greatest need for the learning disability specific service at Willows have been prioritised.

There is currently no system in place for the service to be clear at any one time about how many individuals are being disadvantaged by this situation. The hospital manager told us there is a learning disability service-wide review planned.

Recommendation 8:

The consultant psychiatrist should arrange for a record to be kept of individuals who are waiting to access a bed in the Willows Unit, which can be used to inform the planned learning disability service review.

We wrote to the complex care manager and individual social workers to ask for updates in some individual circumstances. We also asked them to look at how communication can be improved so that individual patients were aware of the efforts that were being made on their behalf, and updated regularly.

Summary of recommendations

1. The senior charge nurse should ensure that a form that includes information about the social circumstances of the individual is completed as far as possible and held with the person's notes so it is readily accessible to all staff working with that individual.
2. The senior charge nurse should review care plans to ensure that they are individualised and streamlined to aid 'usability'. Where appropriate, accessible plans should be developed to aid patient input into their care planning.
3. The hospital manager should develop a locked door policy in an easy read format for patients.
4. The hospital manager should introduce a 'use of seclusion' policy in line with the Commission's guidelines.
5. The hospital manager should arrange for the completion of training in specified persons regulations for nursing and medical staff as soon as possible.
6. The hospital manager should ensure the provision of curtains on the inside of the rooms, which can be removed if observation is required. This ensures privacy is managed by the patient where appropriate.

7. The senior charge nurse should ensure that patients have easy access to drinking water.
8. The consultant psychiatrist should arrange for a record to be kept of individuals who are waiting to access a bed in the Willows Unit, which can be used to inform the planned learning disability service review.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Kate Fearnley

Executive Officer (Engagement and Participation)

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 MWC 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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