Mental Welfare Commission for Scotland

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

Date of visit: 3 February 2016

Where we visited

The Willows Unit is a six bed 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 Psychiatric Intensive Care Unit. Three other service users with a learning disability placed in other wards in New Craigs Hospital would have been more appropriate in Willows. We last visited this service on the 22 September 2015 on a national themed visit and made recommendations on the following matters:

- Notes and care plans were difficult to navigate and it was not easy to see at a glance the level of participation of each individual patient in meaningful activities.

- We did not see sufficient evidence of how the input of allied health professionals contributed to care planning and risk assessments. A consistent approach to documenting review dates in care plans is also needed.

- The use of seclusion policy needs to be implemented.

- T2 and T3 certificates for consent to treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) were not consistently kept with the medication kardex and some treatment authorisation did not exist.

We also visited in October 2013 and made recommendations about the lack of clinical nurse leadership.

On the day of this visit we wanted to follow up on the previous recommendations and also to look at clinical leadership issues. This is because there has been no lead nurse in learning disability for some time.

Who we met with

We met with four patients and reviewed their notes. No carers, relatives or friends were available on the day of this unannounced visit.

We also spoke with the acting charge nurse and several staff nurses.

Commission visitors

Tony Jevon, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

During our visit to the Willows Unit in October 2013 we asked about the lack of clinical nurse leadership. There was no senior charge nurse in post and staff told us in 2013 that this was affecting the clinical management and direction of the in-patient service. We were re-assured at the time that there was input from a nurse consultant for learning disabilities who provided clinical advice and support to the nursing team in Willows, but not clinical nurse management. The hospital nurse manager also attended the ward on almost a daily basis to meet with and guide nurses to fill this gap. We were also told in 2013 that a senior charge nurse job description was being advertised and would be appointed.

On this visit we asked again about the appointment of a senior charge nurse and were told that despite efforts to recruit to this post, including changing the role to make it more attractive, NHS Highland has been unable to appoint to this post. In 2013 we wrote 'Having regard to the lack of clinical leadership and the potential impact this has for a group of vulnerable individuals and patient safety, hospital managers should take action to appoint a clinical lead as a matter of urgency'.

We acknowledge that the availability of a nurse consultant and the support of the hospital nurse manager ameliorate the problem but we remain of the opinion that a senior clinical learning disability nurse to provide leadership for this service is an essential component of the assessment and treatment unit.

In relation to the proper recording and filing of care plans and assessments the hospital nurse manager had written to the Commission on the 11 January 2016. He told us that they had identified the lack of a ward clerk as being crucial to this issue and that by appointing someone with administration skills this had now been remedied. However, on the day of our visit no ward clerk had started, but staff had been reassured one would be starting shortly. As such this continued to be an issue, albeit one that will hopefully now be addressed with the appointment of a ward clerk.

Recommendation 1

Hospital managers should address the availability of clinical nurse leadership for the ward.

Use of mental health and incapacity legislation

The correctness of T2 and T3 certificates for consent to treatment under the Mental Health Act were also an issue raised on our previous visit. The hospital nurse manager agreed at the time to remind the responsible medical officer (RMO) and the pharmacist to review these at subsequent multi-disciplinary team meetings.

On this visit one patient we met who was on a compulsory treatment order (CTO) did not appear to have any consent to treatment authority. Another who was described as having a learning disability, with acquired brain injury, exacerbated by alcohol misuse and significant cognitive impairment was treated with the authorisation of a T2 from 2014. This is a certificate for consent to treatment indicating that he had the capacity to give full meaningful consent to his medication. This appeared to be in conflict with a more recent s47 treatment certificate under the Adults with Incapacity (Scotland) Act 2000 (the Adults with Incapacity Act) completed by his GP indicating that he lacked the capacity to give full meaningful consent to his medication. Another patient seen had a guardian appointed with power to consent or to withhold consent to treatment and a clear statement in Mental Health Act paperwork from his RMO that he has a significant impairment preventing him from making informed decisions, and has little or no insight into his condition. However, he also had signed a T2 certificate for consent to treatment. The acting charge nurse agreed to ask the RMO and pharmacist to review consent to treatment authorisation for all the patients.

Recommendation 2

The responsible medical officer and pharmacist should review consent to treatment authorisation for all the patients and write to the Commission once this has been completed.

Rights and restrictions

One Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form completed when the patient was very ill in Raigmore now may not reflect their current circumstances and the appointment of a welfare guardian. I asked for it to be reviewed.

In our previous feedback to the hospital from September 2015 we noted that there had been occasional use of seclusion and that there was no hospital policy to support this. The Hospital nurse manager had written to the Commission since our last visit to note that there had only been one patient who had required to be taken to her bedroom where she remained until calm. This was felt to be the least restrictive approach and one that had been used successfully by her parents when she lived at home. The patient was no longer in the hospital and there was no plan to use seclusion in future.

Despite this, I discussed with the acting charge nurse that having a policy, with forms for recording usage in place, meant that such infrequent or exceptional uses of seclusion could be properly monitored and reviewed.

Recommendation 3

Hospital managers should ensure that a ‘use of seclusion’ policy is written in line with the Commission’s published guide.

Activity and occupation

The hospital nurse manager had also written to reassure us in his letter of the 11 January 2016 that he had asked nursing staff to record when and for what reasons activities are cancelled so that this can be monitored. On the day of our visit this had not yet been implemented. The acting charge nurse confirmed she had received a request from the Hospital nurse manager for this to commence on the day of our unannounced visit, and that this would now be implemented.

We heard on the day of our visit that nursing staff still struggle to provide programmed activities, but that support from allied health professionals, including psychology, occupational and speech and language therapy, had increased. They have been asked to document their input more clearly on care plans and assessments and we saw some evidence of this.

Summary of recommendations

1. Hospital managers should address the availability of clinical nurse leadership for the ward.
2. The RMO and pharmacist should review consent to treatment authorisation for all the patients and write to the Commission once this has been completed.
3. Hospital managers should ensure that a ‘use of seclusion’ policy is written in line with the Commission’s published guide.

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 Director (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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