Mental Welfare Commission for Scotland

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

Date of visit: 25 February 2016

Where we visited

The wards in Iona and Lewis hubs have a range of patients with varying degrees of mental illness and learning disabilities. The wards provide assessment and continuing care/rehabilitation. All patients are required to have care in a maximum security hospital setting. There is a full range of multidisciplinary input to care and treatment supported by medical records, medical secretaries and administration.

We last visited the State Hospital on 8 September 2015, when we met with patients in Mull and Arran hubs. We last visited Lewis and Iona hubs on 19 February 2015. There were no recommendations made on the latter visit.

There were some issues identified from previous visits; from telephone contact with patients; and from meeting with advocacy services, PFPI service, and social work staff. Concerns were raised with regard to: the environment; patients moving between wards; and individuals admitted to the State Hospital due to a shortage of available beds in medium secure units. Our reason for visiting on this occasion was to look at these issues.

Who we met with

We met with 16 patients and reviewed a further 9 files.

We spoke with the service manager, team leaders, ward managers and other nursing staff.

In addition we met with social work, advocacy and patient involvement staff.

Commission visitors

Steven Morgan, Medical Officer; Douglas Seath, Nursing Officer; Mike Diamond, Executive Director, Social Work; Mary Hattie, Nursing Officer; Mary Leroy, Nursing Officer; Paula John, Social Work Officer; Jamie Aarons, Social Work Officer.

What people told us and what we found

Care, treatment, support and participation

We reviewed care plans for all the people we saw on the day. We found good examples of risk assessments being completed and updated We felt that the general care planning information was detailed and personalised and we could see that care plans were being regularly reviewed. We found evidence that care plans were being made more accessible to patients with learning disabilities by using diagrams and symbols.

We found good evidence of multi professional working with patients having regular input from psychological therapies, occupational therapy, dietetic and SALT staff.

Use of mental health and incapacity legislation

The majority of files we reviewed had the necessary consent to treatment forms under the Mental Health Act and Adults with Incapacity Act. Copies of forms were generally in place with the medicine prescription. There were two cases where the prescriptions were not compliant with the treatment authorised by T2/T3 mental health act consent to treatment forms. These issues were raised with staff on the day and followed up with the RMO after the visit.

Recommendation 1:

Managers should ensure compliance with consent to treatment requirements under the Mental Health Act by regular audit of medication prescriptions.

Rights and restrictions

A number of patients were subject to enhanced levels of observation; some with 2:1 and 3:1 ratios of nursing staff to individual patient. This reduces the risk of harm to the patient and to others but puts an increased burden on the nursing resource across the service. However, commission visitors found that in all cases reviewed, there were appropriate risk assessments in place and that these were reviewed on a regular basis. We were informed that this issue is the subject of an ongoing research project.

Some patients visited were also subject to periods of seclusion. There are purpose built suites within each ward for this eventuality and we found evidence that periods of seclusion were kept to a minimum and patients had no issues to raise with respect to this. The suites include a bedroom and sitting area which allow for periods of separation from others without necessarily being in the seclusion room. Patients are gradually reintegrated into the ward by use of enhanced levels of observation until assessed as no longer requiring this.

We were also informed that a number of patients have been assessed as ready for discharge to conditions of lesser security but that due to lack of availability of beds the moves have been delayed. Many of these patients have lodged appeals with the Mental Health Tribunal for Scotland because of this.

Activity and occupation

Most patients who choose to participate have access to regular activities with weekly programmes in place. Many attend the Skye Centre within the hospital and patients spoke favourably about the resource there. Two patients, as well as staff, commented on the fact that clinical demands can lead to the cancellation or postponement of activities.

The physical environment

Visitors noted the need for replacement of carpets and chairs during our visit last year. We were pleased to see that there is a programme of replacement for worn and damaged carpets and chairs and that this is progressing well. We also noted the refurbishment of damaged seclusion suites has led to safer rooms with electrical sockets and switches less accessible and en suite doors being replaced where broken.

Some patients complained of problems with heat regulation with wards being cold in winter and hot in summer. This matter has been brought to the attention of the estates department for review.

Any other comments

There were three patients admitted to the State Hospital who had been assessed as requiring medium secure level of restriction. Of the patients we interviewed, all had been informed of their rights and at least one patient is appealing against excessive security. We feel that the admission of patients not requiring high security is not an acceptable practice and would strongly advise that it is discussed at the forensic network to try to find a solution which does not disadvantage individuals in this way.

Some of the patients with learning disabilities have been transferred from their specialist ward to wards for individuals with mental health problems. The situation has come about due to interpersonal conflict between individuals in the ward. Although this has removed the potential for conflict, it leaves those individuals without the specialist nursing input they would have had. Although we noted that adaptations have been made for some patients in their new environment, it was unclear from the visit the level of specialist input those individuals were receiving in their current wards.

Finally, visitors to one ward (Iona 2), found that the nurse in charge was unaware of the Commission visit, in spite of the advance notice by letter and supply of posters for patients and visitors. The lack of evidence of the visit being advertised in the ward meant that, due to the lack of information, patients who wanted to be interviewed had no access to advocacy on the day.

Recommendation 2:

Senior nursing staff should review the specialist nursing input to individuals with learning disabilities relocated to other wards to ensure they are given appropriate care and support commensurate with their assessed needs.

Recommendation 3:

Managers should ensure that commission visits are widely advertised within wards so that individuals can plan for the interview and arrange support from advocacy.

Summary of recommendations

Recommendation 1:

Managers should ensure compliance with consent to treatment requirements under the Mental Health Act by regular audit of medication prescriptions

Recommendation 2:

Senior nursing staff should review the specialist nursing input to individuals with learning disabilities relocated to other wards to ensure they are given appropriate care and support commensurate with their assessed needs

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Good practice

Patients were generally positive about their care and support and gave good feedback about relationships with nursing staff.

Visitors were impressed with the quality of the records accessed via the Rio patient information system, once we had overcome some initial logging in problems.

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.

Mike Diamond

Executive Director (Social Work)

12 April 2016

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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