Mental Welfare Commission for Scotland

Report on announced visit to:
Western Isles Hospital, Acute Psychiatric Unit, Macauley Road, Stornoway, HS1 2AF

Date of visit: 15 April 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The Acute Psychiatric Unit in the Western Isles is a mixed-sex, five-bedded adult acute mental health assessment ward. The ward covers the catchment area of the whole of the Western Isles. On the day of the visit, there were two individuals receiving care and treatment on the ward.

We last visited the ward on the 17 October 2023 on an unannounced visit. We made recommendations in relation to care plans, access to off-island placements, policy and protocol on enhanced observation and the use of seclusion, recruitment of clinical psychology and s47 certificates under the Adults with Incapacity (Scotland) Act 2000 (AWI Act). On the day of this visit, we wanted to follow up on the previous recommendations, meet with people and review the range of care and treatment provided on the ward.

On the day of the visit, two of the five bedrooms were closed for planned refurbishment, to ensure compliance with anti-ligature policy and practice. We were told about a rolling programme commencing the next day to complete improvement work on all five bedrooms. We noted that contingency plans had been agreed with the community mental health team, who would have additional agency nursing staff to bolster capacity due to the temporary reduction in the available in-patient beds.

Who we met with

We met with and reviewed the care of the two individuals admitted to the ward. We did not meet any relatives or carers on the day but had asked staff prior to the visit specifically to inform relatives and carers.

We spoke with the associate director of mental health and learning disability and the acting senior charge nurse (ASCN).

Commission visitors

Audrey Graham, social work officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Care, treatment, support, and participation

The two individuals we met with told us much that was positive about the approach of the staff in delivering care and treatment. We heard that there was kindness shown and that "staff are great". We heard about conversations with staff which were therapeutic, meaningful and helpful. One individual advised that the responsible medical officer's (RMOs) formulation of their issues had been "very good" and had helped them to understand their experiences of mental distress.

One individual, while sharing positive views, also shared concern that there was not a well-developed understanding of the use of power and restrictive practices. They said, "staff unconsciously use power and unconsciously restrict rights". They expressed frustration that there was a planned discharge date in two days' time but felt they were still being restricted. We did note that despite the imminent discharge, permitted time out of the ward was still quite limited for this individual and they remained subject to detention under Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

This was raised with the associate director and the ASCN, who noted a difference in views across the staff team regarding legal status and agreed time out of the ward for this individual. We undertook to write to the RMO raising the contradictions we observed in terms of least restrictive practice and care planning.

There continued to be difficulty in finding specialist beds, such as for intensive psychiatric care and specialist older peoples' care. We were told that identifying a specialist bed could involve RMOs calling bed managers across the country, with this sometimes taking all or most of a day. There was a previous recommendation made around the need for a service level agreement for these services with another health board and the Western Isles Health Board committed to doing this in the action plan they returned to us.

We were disappointed to find that this had not been achieved and in fact there had been very little progress with this since our last visit in 2023 and we felt this now required to be escalated to the chief executive and the chief officer. We advised that the Commission would write to both to strongly advise that this is taken forward, as per the action plan provided. We were pleased to note that a formal agreement allowing access to in-patient beds at the Dudhope Unit in Dundee was in place for children and young people.

Recommendation 1:
The chief executive and the chief officer should ensure that a means to access specialist beds is put in place so that individuals receive appropriate care and timely transfers, as and when required.

Care records
Care records were held on paper and were a mixture of handwritten and typed documents. Some of the handwritten records were difficult to read. Care records were easy to navigate, and it was clear to see where specific information was located, including Mental Health Act paperwork. The information held in the daily care records was of a high standard and included several entries through the course of the day giving a clear sense of how the individual had presented, what they had achieved and what had been challenging for them.

Care plans were person-centred and reflected the individual's perspective and agreed goals and interventions. There was space for the individual to sign the care plan and there was evidence of review and discontinuation where appropriate. One individual told us that they had only received a copy of their care plans because they had asked. The Commission believe that paper copies should be offered routinely and be in accessible format to aid individuals' ownership, understanding and focus on identified goals. One individual told us "if they used my words in the care plans then I would take responsibility for them".

One individual had multiple physical health issues, which were not fully reflected in the care plan, and this was raised with the ASCN on the day who agreed to address this. It was encouraging to see use of strengths-based relapse prevention/staying well plans completed in partnership with individuals. We could not see evidence of care plans being audited but were reassured in discussion with the ASCN that there was an audit process in place, which had temporarily stalled due to staff sickness but would be re-starting imminently.

Risk assessments were in place and recorded on the Sainsbury tool. These were completed by the RMO and were thorough, detailed and person-centred. We did feel that risk assessment and risk management was not fully reflected in care plans and the two that we looked at were overdue for review. It is important that identified risks are fully reflected in care plans, which should be completed in partnership with individuals to promote understanding and help the individual take personal responsibility.

We also noted that the risk assessments were handwritten and difficult to read. This was a concern, as it is important that information on risk and its management is easy to access for all staff, particularly for agency of bank staff who might not know people so well.

Recommendation 2:
Risk assessments should be typed, regularly reviewed and be fully reflected in the individuals' care plans.

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 ward had an MDT on site consisting of nursing staff, psychiatrists and occupational therapy, who provided an in-reach service from the main hospital. It was encouraging to be told that the previous challenge with recruitment of clinical psychologists had moved on positively. We were advised that a principal psychologist had been appointed following agreement that they could primarily work from the mainland. This had previously been an arrangement that senior management had wished to avoid but given the specific and long-term challenges posed by the island setting, we agreed that the arrangement was necessary but should be kept under regular review.

A clinical psychology post was also being recruited to and we were advised that there was good in-reach to the ward from the community psychology service meantime. Referrals were made to other services, such as physiotherapy and social work as required. From discussion with the ASCN, we felt there was regular communication with community psychiatric nurses (CPNs) across the various islands, with set days for check-ins to take place at the weekend and every Tuesday and Thursday.

We were told that challenges related to staffing had been ongoing for some time. The ward was staffed by two registered mental health nurses (RMNs) through the day and one RMN and a clinical support worker at night. The ASCN generally worked Monday to Friday, 9am to 5pm and offered additional capacity in delivering care when possible. It had been necessary on the day of the visit however for the ASCN to work as half of the team of two registered nurses. We were advised that the impact of long-term sickness amongst the staff group was significant, particularly considering it was a small team.

Use of agency staff was a regular occurrence, however they did have a small core of agency workers who were dependable and knew the ward well. We asked about contingency plans should there be a crisis requiring additional staff, for example, if physical restraint was required to keep someone safe. We were told that when required, support was mobilised from the wider hospital health and safety team and that these staff were suitably trained. The police were also called if required.

There were three consultant psychiatrists covering two posts and their MDT meetings were held weekly. The recording of these meetings was detailed and provided a holistic record of the individual's progress across the week. A section for

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

the individuals' views was included which was completed fully for the most part. It was apparent from records that individual's and carers were being invited and attending. There was evidence of actions identified at MDTs being followed through.

There was some variability in the standard of recording details, such as who attended meetings. We noted three different proformas in use and discussed the need to streamline recording of MDTs with the ASCN. We thought accountability for identified actions could also be improved by adding a section to indicate who was responsible and by when, as well as entries from different professionals within the proforma being initialled. This was discussed on the day and the ASCN agreed to progress.

We were told of a recent serious incident where a member of staff was injured by a person who had gained entry to the ward. The review into the incident was ongoing, however, action had been taken to install a keypad outside the door, so that entry was controlled but people could freely exit by pressing a button. We were told that due to staff sickness, it had been necessary for a very senior staff member to take on basic administrative tasks relating to use of the Mental Health Act, such as the statutory notifications. The lack of capacity in administration services to absorb these tasks was of concern. We also identified a notable gap in terms of senior nursing leadership for mental health nursing staff in that there is no post which sits between the SCN and the associate director of mental health and learning disability. We were concerned about the potential impact of insufficient capacity for effective governance, clinical leadership, quality assurance, support and supervision of nursing staff.

Recommendation 3:
Senior management should consider creating a clinical lead nurse post (or equivalent) for mental health.

Use of mental health and incapacity legislation

On the day of our visit one individual was detained under the Mental Health Act. This person had a good understanding of their detained status but despite being referred to the local advocacy service 10 days previously, they had still not been visited by them.

All documentation relating to the Mental Health Act was in order and easily located in files. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained people, who are either capable or incapable of consenting to specific treatments.

Neither individual on the ward required a T2 (consent to treatment certificate) or a T3 (certificate authorising treatment) due to their current detention status. We did note from a review of the electronic prescription records, that the individual who was

informal was prescribed intramuscular (IM) antipsychotic medication on an ‘as required’ basis. The Commission has concerns about IM ‘as required’ medication being prescribed for people who are informal. This is because it is likely that they would not be consenting to receive the treatment if it was later administered. We consider it best practice for a medical review to be arranged if circumstances arise where IM medication may be required.

We asked that this prescription be reviewed and the ASCN agreed to discuss this with the RMO.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

One patient had a section 47 certificate which had been put in place a few days before we visited. The previous certificate had expired in November 2024 so there was a gap of around five months where no certificate had been in place. We noted that there was a prompt on the MDT proforma relating to section 47 certificates, but that some versions of the form did not have this. It is hoped that by ensuring the most up to date version of the MDT proforma is used, as discussed with the ASCN, that this will provide sufficient prompting for staff to ensure that section 47 certificates do not lapse.

The section 47 certificate we reviewed had no treatment plan attached and this was also an omission noted at the previous visit. This was raised with the associate director of mental health and learning disability and the ASCN on the day.

Recommendation 4:
Senior managers and medical staff should ensure that, where a patient lacks capacity in relation to decisions about medical treatment section 47 certificates, and where necessary, treatment plans must be completed and cover all relevant medical treatment the individual is receiving.

Rights and restrictions

Discussion with staff on the day of the visit offered reassurance that they were clear on their status as an open ward. As discussed, entry to the ward was controlled for reasons of safety, but people could exit freely by pressing a button. We asked how the risk of absconsion was managed and were advised that agency staff were brought in and the individual placed on an enhanced level of observation, commensurate with the risk posed.

We were told by staff that advocacy services were responsive, however we did note that one individual who was detained had been referred 10 days previously but had not yet met with advocacy. The ASCN confirmed they had also noted this and were following up. Staff advised that social work responded promptly and were involved in care planning as necessary, although there were challenges in terms of working relationships at times due to differing priorities.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. Neither of the two people we met with had an advance statement, however one person had a blank template and intended to complete this.

It was positive to hear that staff promoted the making of advance statements at the point of admission and gave written information to orientate individuals and promote their rights in the form of an 'admission pack' and a 'rights pack'. One person had made their own folder and did not seem to be aware of the ward information. It may be advisable that staff re-visit this essential information with individuals a few days into admission or when there is some settling of more acute symptoms.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There was no-one subject to specified persons restrictions when we visited.

As noted, there was one individual who remained subject to detention and had restrictions placed on time out of the ward but was due to be discharged in two days' time. They expressed strong views that the approach was overly restrictive and that there was not full understanding amongst the staff group of human rights and restrictive practices. There did appear to us to be contradictions in the care plan in this case which were raised on the day of the visit.

From discussions with staff, it was noted that, while practice in terms of observation and seclusion had moved in line with current guidance following recommendations from the visit in October 2023, policy and procedure had not been drafted to reflect this. We were advised that this was due to long term sickness of the senior staff member tasked with completion and that it would be prioritised when they returned. We were reassured that their return was imminent.

The Commission has produced good practice guidance in the use of seclusion[2].

The Commission has also developed *Rights in Mind.*[3] 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.

Recommendation 5:
Senior managers should ensure that nursing staff base their observation practice on Scottish Patient Safety Programme 'Improving Observation Practice' guidance and alter their policy accordingly.

Recommendation 6:
Senior managers should put in place a policy to regulate the use of seclusion and implement a protocol for its use to ensure individuals' rights are upheld at all times.

Activity and occupation

Staff advised that support to engage in activities took place on a one-to-one, rather than a group basis. There was a large activity room with a pool table and arts and crafts supplies which individuals could access on request. One person said that they had enjoyed painting while in the ward. OT input was on a referral and in-reach basis. We noted that this post also covered mental health services in the community, however were reassured by staff that the OT was responsive when required.

There was an activity timetable in place, but the range of activities was quite restricted. We discussed a need for the staff group to spend some time reviewing and refreshing the range of activities on offer. We did not see individualised care plans relating to meaningful activity and we advised that these would be desirable. Specific care planning in this area could be important in identifying past and present interests, issues relating to motivation or accessibility and the best approach to encouraging engagement.

Recommendation 7:
Senior managers should ensure there is a range of meaningful and individualised activities in and out with the ward environment, which is flexible and informed by person-centred care planning.

The physical environment

The ward consisted of five single ensuite bedrooms, which were all suitable for disabled access. Overall, the environment was clean and spacious.

There was a lounge and activity room and a shared dining area. The lounge was not being used by either individual when we visited, and it did not feel particularly

[2] *Use of seclusion good practice guide:* https://www.mwcscot.org.uk/node/1243
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

inviting. We discussed with senior staff present whether consideration could be given to investing some resources to upgrade the room and make it more comfortable, homely and appealing.

There was a laundry room and a small kitchen which individuals could use when they wanted, with supplies of snacks, fruit, juice, tea and coffee. The ward had a large, well maintained, enclosed garden, which was shared with other wards.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
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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 an individual's care, treatment, and support are 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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