

Mental Welfare Commission for Scotland

Report on unannounced visit to:

The Huntercombe Hospital, Binny Estate, Ecclesmachan Road,
Uphall, West Lothian, EH52 6NL

Date of visit: 6 December 2016

Where we visited

The Huntercombe Hospital is a 22 bedded private hospital providing inpatient mental health assessment and treatment for young people aged 11-18 years. A dedicated programme for the treatment of eating disorders is provided, as well as a generic children and adolescent mental health service (CAMHS). The majority of admissions are for treatment of eating disorders. We last visited this service on 24 August 2015 on an announced visit and made recommendations regarding activities, care plans, patient information, observation policy and restrictions and patients' rights.

On the day of this visit we wanted to follow up on the previous recommendations. We also wanted to look in more detail at the experiences of patients from outside Scotland who are receiving treatment at the Huntercombe Hospital. This is because the Mental Welfare Commission (the Commission) has become aware of increasing numbers of patients being transferred to the unit from NHS England. In addition the Commission had been informed by Healthcare Improvement Scotland (HIS) of the high use of nasogastric feeds which we wanted to hear more about.

Who we met with

We met with and or reviewed the care and treatment of all six patients. No relatives were available to speak with us during the visit.

We spoke with the hospital director, the acting ward manager, both consultant psychiatrists and an advocacy worker.

Commission visitors

Margo Fyfe, Nursing Officer and visit co-ordinator

Dr Stephen Anderson, Commission Consultant Psychiatrist

Dr Unoma Okudo, Temporary Medical Officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit there were six patients resident in the service. Five of the patients were detained and all were from England.

Commission visitors were informed that the service had chosen to restrict admissions earlier in the year to ensure a patient who required enhanced care was given this appropriately. The service was beginning to admit more patients on the day of the visit. We were also told there had been a large turnover in nursing staff with five new staff nurses having just been recruited.

It was good to hear that in addition to psychiatrists and nurses there is a new occupational therapist in post. The service also has a family therapist, a therapist that offers cognitive behavioural therapy and family work, a psychologist and a psychology assistant, an art therapist and a dietician who is there three days per week as well as social work and teaching staff. A pharmacist also visits weekly and audits medication prescriptions.

Care Plans

The service has now moved to electronic record keeping. We had the opportunity to look at all of the patients' records during the visit. We found care plans to be person-centred with a clear recovery focus. Where the patients were managed under the care programme approach (CPA) the care plans linked to these appropriately. There was good evidence that patients had been involved in creating their care plans with their views clearly noted in the care file. We note that the care plans are audited monthly.

From the notes it was clear that family are encouraged to participate in care planning and to participate in therapeutic interventions such as family therapy as well as attending review meetings. We were informed that families are encouraged to visit weekly if this is appropriate for the patient, and to keep in contact with the young people via telephone and Skype. There is an electronic tablet device available for patient use for Skype or Facetime with their family between visits. Parents/carers are supported financially by the Huntercombe Group to visit twice per month. Family contact is recorded in the care file.

Although we saw that care plans were being reviewed, the reviews lacked detail in regard to interventions and progress. It is important to record care plan reviews in more detail to ensure interventions are useful and working for the patients.

Patient feedback

The young people we spoke with chose to be seen as a group rather than on their own. They praised the staff saying that they were always available to give support when needed. They all agreed they liked the accommodation and enjoyed having their own toilet facilities. They were fully aware of what restrictions were in place regarding what they could have in their rooms and seemed to understand why this was in place. They knew they could not have smart phones but did have access to basic mobile phones. Although they were not allowed to freely access the internet they were allowed to use this in school sessions for research and under staff supervision for online shopping. They said they were able to use the unit ipad to Skype or Facetime their family when they wished.

They had all been given information prior to admission about the service and some had visited the unit before admission.

They were happy to be involved in developing a new welcome pack as they all agreed there was more information they would have found helpful to have in advance of admission. The patients who were detained were aware of their rights and that they could seek advocacy assistance if they wished.

They spoke about the group work they were involved in and the social activities they enjoyed. They did however, say that weekends, if family were not visiting, were boring as due to recent staffing issues they have not been able to go on outings or to have groups facilitated.

All of the young people have school work and this is provided on the English curriculum. The young people were aware that their home school is contacted for a report on what they are doing in order that they keep up with appropriate schoolwork for their return home.

In general they said being far from home was not ideal but they were glad family could be there most weekends and really looked forward to these visits.

Patient transfers from outside Scotland

At the time of this visit all of the patients in the unit were from England. We heard that families are encouraged to visit weekly or fortnightly depending on what is appropriate for the patient. The Huntercombe Group provide support and liaise with local authorities where appropriate regarding financing visits for parents/carers twice per month. This allows families to participate in therapeutic family work as well as spending recreational time with the young people.

We heard that all referrals are now assessed by the consultant psychiatrists in the unit prior to being accepted for admission. Where it is deemed necessary one of the psychiatrists will visit potential patients prior to admission. Where possible, visits to the unit are arranged in advance. Patients and families are also given information packs in advance of admissions.

It was good to note that patients are encouraged to keep in touch with families between visits by telephone and Skype or Facetime.

Although we noted good efforts in engaging families and encouraging contact, we heard from the young people that it is difficult being so far away from home.

Recommendation 1:

Managers should ensure all staff are aware of how to fully document reviews of care plans and that the monthly audit covers this area to ensure all care plans have clear meaningful reviews in place.

Use of mental health and incapacity legislation

Consent to treatment and medication prescriptions

We were pleased to see that consent to treatment certificates (T2) and certificates authorising treatment for detained patients (T3) forms were present in the ward prescription file. We noted that one record of notification following urgent medical treatment form (T4) had not been fully completed and addressed this with the consultant psychiatrist during the visit.

We noted that one prescription sheet had regular medication being recorded as given 'as required', the T3 had all of the prescribed medication authorised for regular use. We discussed this and recommended that the medication prescription be changed to ensure the alternative routes of administration are covered in the regular use part of the prescription.

Recommendation 2:

Medical staff should ensure that medication prescription sheets for regular medications have all routes of administration that may be used included on the prescription sheet.

Rights and restrictions

Observations

The observation policy has been reviewed and new paperwork has been produced to more clearly record any enhanced observations. We were happy to note that 15 minute observations are no longer being carried out. Unfortunately, we found that staff were not completing the new forms appropriately, and that information on what the patient was engaging in during observation was being missed. We discussed this with the acting ward manager on the day and hope to see this issue resolved on future visits. We were told that observation levels are discussed at weekly team meetings and reviewed daily when put in place.

Risk Assessments

Risk assessments were detailed and regularly reviewed. We particularly liked the risk management review template that was completed for each patient.

Restraint

We were informed that the restraint model used in the unit is the Protecting Rights in a Caring Environment (PRICE) model and that all staff had undergone appropriate training. This training will be extended to the new staff when they start.

We saw specialist equipment that is used during nasogastric feeding and discussed the use of these with managers.

We were informed any forms of mechanical restraint considered are no different from that used in NHS eating disorder units elsewhere. At present the use of mechanical restraint is being further investigated by the Huntercombe team as they consider whether to use it in future. We advised contacting the State Hospital for advice on the use of mechanical restraint. We expect to be kept informed of the development of policies for the use of these items and we plan to discuss with other Scottish NHS services their policies and procedures around the use of these items.

Patients' rights

The detained patients we spoke with were aware of their right of appeal and that they could access advocacy services for support. We were informed that the social work staff normally monitor the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 (MHA) however, one social work assistant has left the service and the other is off ill. At the moment the administration staff have taken on this role. All legal documentation is kept in a file for each patient in the administration office. There is a new social worker starting in early 2017 and this task will revert to the social work team. It would be good practice to make a clear note in care files once patients have been informed of their rights.

The service has historically used an Edinburgh based advocacy service who would visit if a young person asked to be seen. There is now a new advocacy service, Pohwer Advocacy, offering a service. They visit the unit weekly and make themselves available for the day to all patients. It is important that patients fully understand what the advocacy service is about and how it can support them. We urged managers to facilitate patient engagement with the advocacy services when they are on site.

We asked that managers pass on our contact details to any family/carers of young people seen on the day should they wish to discuss anything further.

Recommendation 3:

Director should keep the Commission informed of the development and progress of policies around the use of mechanical restraint.

Activity and occupation

It was good to see a variety of activities on offer to the patients and that participation is recorded in the care file.

We discussed the patients feeling that more could be on offer, if staff were available. We were informed that there are new staff starting and that the new occupational therapist will be moving to a varied shift pattern that will allow the facilitation of group activity outwith core hours and at weekends. We were also told that the young people are asked at the patient forum what activities they would like made available to them.

The physical environment

Accommodation is provided over two floors. Most bedrooms have ensuite facilities. Five bedrooms upstairs have been adapted to include anti-ligature fittings and safety furniture for the provision of safe care for young people with higher levels of need. There is a dining room, several group rooms and a lounge are on the ground floor. The unit also has school facilities.

There is a large outside space for patient use.

Any other comments

Nasogastric feeding

On the day of the visit we were informed that there were only two patients requiring nasogastric feeds and that this was carried out twice a day for one, and four times a day for the other. We noted that appropriate T3 forms had been completed for this intervention. Designated medical practitioners give a second opinion view whenever nasogastric feeding is given under the Mental Health Act.

The Commission had been informed prior to the visit that the unit were using a high rate of nasogastric feeds and that healthcare assistants were going to be asked to carry these out.

At present only staff nurses carry out this intervention. The Huntercombe Group are moving towards upskilling health care assistants (HCAs) to carry out the intervention and some of the HCAs in the unit have been trained on the Nasogastric Peg Feed course for Health Care Assistants run by the Royal Infirmary Edinburgh. We questioned the training at SVQ level of these HCAs and were told they are not SVQ trained. We had been advised that HCAs should be trained to SVQ level 7 before taking on such tasks. We left the SVQ information with managers and suggested they contact NHS Education Scotland for further information.

Staff Training

We heard that staff have undergone various training, including in autism and in rapid tranquilisation. It was encouraging to hear that the acting ward manager and a few other staff have undertaken training modules in children and adolescent mental health (CAMHS). We discussed the benefit of all staff having basic CAMHS training and suggested that managers contact NHS Education Scotland to discuss accessing their online New to CAMHS modular training. We had suggested this in the past and encourage further action in this area.

Summary of recommendations

1. Managers should ensure all staff are aware of how to fully document reviews of care plans and that the monthly audit covers this area to ensure all care plans have clear meaningful reviews in place.
2. Medical staff should ensure that medication prescription sheets for regular medications have all routes of administration that may be used included on the prescription sheet.
3. Director should keep the Commission informed of the development and progress of policies around the use of mechanical restraint.

Good practice

The Commission visitors were pleased to see the efforts made by the service to engage families in care and treatment and to ensure the young people maintain contact with their families especially as they are so far from home.

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)
11 January 2017

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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