



Mental Welfare Commission for Scotland

Report on announced visit to:

Camus Tigh, Kirkhill Road, Broxburn, EH52 6HT

Date of visit: 20 June 2023

Where we visited

Camus Tigh is a six-bedded assessment and treatment unit for male patients with a primary diagnosis of learning disability, and who have complex care needs. The unit, located in a local community in West Lothian, is part of NHS Lothian's learning disability service. The aims and objectives of this service is to provide intensive therapeutic interventions that would help individuals to overcome the symptoms of their illness and return, as soon as possible and with support, to a less restrictive community environment.

On the day of the visit, there were five patients in the unit and one vacant bed. Three patients were awaiting community placement.

We last visited this service on 26 September 2018 and made recommendations in relation to clear actions for patients whose discharge was delayed, review of the observation policy, consistent recording and auditing of the information contained in the patient records and finally the review of T3 certificates.

On the day of this visit we wanted to follow up on the previous recommendations, as well as look at the care and treatment being provided on the ward.

Who we met with

We met with and reviewed the care and treatment of all five patients in the unit. No family members chose to meet with us. Staff told us that the families who had involvement with patients in Camus Tigh have met with the Commission on previous visits and did not have any concerns or issues with the care and treatment of their relatives.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), the consultant psychiatrist, and nursing staff.

Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

We heard that many of the patients had been in hospital for a number of years, for some this was up to six years. Staff we spoke to knew the patients well and had worked with many of them since their admission to Camus Tigh. It was clear that given the amount of time staff had worked with the patient group they had established a positive therapeutic relationship with the patient. Staff knew the patients very well and had adopted a personalised approach to individual patients, using a variety of different methods such as the use of signs and object signifiers. We saw patients seeking out interactions with staff by taking their hands and leading them to areas of the ward, such as the kitchen; we observed staff responding promptly to cues and communication from the patients.

We were unable to have detailed conversations with patients due to the progression of their communication difficulties as result of their severe/profound learning disability. However, throughout the day we introduced ourselves and spoke to a number of patients who were happy to engage with us. Some of the patients were able to respond to our interactions by using non-verbal communication such as smiling, shaking hands and waving. We observed positive interactions between ward staff and patients during our visit and it was evident from these observations and discussions with staff that they were enthusiastic regarding their patients and the care and treatment they provided.

We were pleased to hear that the unit was fully staffed, which meant the use of bank or agency staff was limited. The staff we spoke to on the day of the visit told us that they enjoyed their job and felt part of a supportive team. It was evident that staff were committed to offering high levels of care and treatment to the patients in Camus Tigh. In terms of staff support, we heard that each staff member engaged in personal development planning (PDP) and there were ongoing training opportunities for staff. Staff meetings were held regularly and clinical supervision was available to staff.

We observed the ward to be busy at times, however, the environment was calm and patients appeared to be content and relaxed in the ward. It was evident that patients felt relaxed in all areas of building and regularly sat in the seating area directly outside the nurse's office.

All patients were well presented and had their own individualised style indicative of personal preferences. We also noted times when the patients levels of stress and distress increased and staff responded immediately to support the patient.

The CNM and SCN discussed the importance of having a skilled staff team to work with patients who have such complex needs. They were committed to building staff skills and knowledge, to ensure they had the necessary skills to deliver person-centred, strengths-based, solution-focussed care.

Care records

Information on patients' care and treatment was held both electronically on TrakCare and in various paper files. We found a lack of cohesion between some paper and electronic files. We were of the view that the current recording system required review to ensure all patient information was up-to-date and stored accurately. We discussed this with the CNM and SCN

on the day of the visit and were told that that the use of paper files and the recording of information was being reviewed across NHS Lothian's learning disability inpatient and associated services.

The majority of case records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in Camus Tigh. It was evident from reviewing the case records that patients required high levels of care and support. The patient group could experience significant levels of stress and distress, leading to increased clinical risk due to high levels of self-injurious behaviour and physical aggression. We were pleased to note that the MDT were actively involved in providing the support, care and treatment to patients at these times.

The case notes we reviewed evidenced person-centred and individualised information, detailing what activities the patient had engaged in that day and what had been positive or challenging. We were pleased to see comprehensive recording from all members of the MDT. There was evidence of frequent one-to-one interactions between the majority of the MDT and patients and we were pleased to find that the case notes included regular communication with families and relevant professionals.

Section 76 (1) of the Mental Health (Care and Treatment)(Scotland) Act 2003 (the Mental Health Act), states that where a compulsory treatment order has been made in respect of a patient, the patient's responsible medical officer should prepare a care plan relating to the patient and include it in the patient's medical records. We were pleased to find that all patient files we reviewed had a copy of a S76 care plan.

All patients were subject to the Care Planning Approach (CPA) and we found this paperwork to be of a high standard and regularly reviewed.

We saw good evidence of discharge planning. Three of the patients were working towards discharge and there were records of regular meetings attended by the MDT, the discharge co-ordinator, community services and family/carers where appropriate. Some of the patients had regular contact with the third sector provider who would be supporting them in the transition to their community placement. We were pleased to note that advocacy were also involved with discharge planning meetings.

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. The care and treatment plans we reviewed provided comprehensive and detailed information, reflecting the complexity of the care that was being provided in the unit. It was also positive to see that information in the care plans linked with the information in the case records. All patients had comprehensive risk assessments.

We saw that physical health care needs were being addressed and followed up appropriately. We were pleased to hear that the unit had a good working relationship with the local GP practice, with the GP and RMO jointly completing annual health checks on each patient. We noted onward referrals to relevant services, where appropriate.

The files we reviewed included details of personal history and a social story which included photographs, the patient's likes and dislikes and details of family/carers. We found the care plans to be mainly focussed on risk and treatment, however, care plans also demonstrated a person-centred approach that included goals and nursing interventions. The care plans were regularly reviewed by the MDT.

The participation of the patients in their care plans was very limited, however, family and carers had involvement in longer term care planning. We were pleased to see the level of involvement that patients had in their day-to-day care, such as making choices in relation to clothing, meals and activities. This engagement was supported by the use of signs, photos, symbols and object signifiers.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was one consultant psychiatrist and an activities co-ordinator. The unit also has two housekeepers who were responsible for domestic tasks and cooking on site and were valued members of the MDT. The unit had access to community occupational therapy (OT), speech and language therapy, a dietician and a discharge co-ordinator. Social work and Mental Health Officer (MHO) staff were part of the wider MDT team. We saw good evidence of an MDT approach in providing personalised care.

Members of the MDT attended a weekly meeting in the unit. The patient's participation in this MDT meeting was limited. We were told that families who had involvement in their relatives care were invited to attend the meetings. There was evidence from the MDT records that family members, or guardians/proxies who had been appointed, were involved in decision-making.

The MDT meeting was recorded on TRAKCare. We found detailed recording of the MDT discussion, decisions and personalised care planning for the patients. We were pleased to see clear links between MDT discussion and the care plan outcomes. It was clear that everyone in the MDT was fully involved in the care of patients.

At the time of our visit, there was no psychology input into Camus Tigh. We were told that referrals to psychology are made for patients if required. This concerned us, as psychology input has a key role in creating and implementing Positive Behaviour Support (PBS) plans for patients with a diagnosis of learning disability and/or autism. One of the patients we reviewed had previously had psychology intervention with a functional behavioural analysis being completed. The assessment included a sensory assessment and mind map for the patient, alongside an intervention plan. The plan gave the staff detailed and practical strategies for managing the patient's complex care needs. However, the use of PBS was not consistent for all patients due to limited psychology input. We heard on the day of the visit that regular psychology input to the MDT would be of benefit to all patients in Camus Tigh, given the complex needs of the patient group. We felt that psychological input was necessary to support the formulation of care and treatment for patients.

Recommendation 1:

Managers should urgently review the psychology provision to the unit.

Use of mental health and incapacity legislation

On the day of our visit, all five patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients did not have an understanding of their legal status, due to the severity of their cognitive impairment, however, we found evidence of curator ad litem being appointed for all patients so that patients were represented and their interests protected in the proceedings for the Mental Health Tribunal. The files we reviewed evidenced involvement of advocacy.

All documentation relating to the Mental Health Act was stored electronically on TrakCare and easily located.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We were pleased to find that recommendation in the 2018 report had been progressed with all certificates authorising treatment (T3) reviewed and renewed in a three year period.

All patients were subject to guardianship under the Adults with Incapacity (Scotland) Act 2000 (AWIA). We found all documentation in relation to details of welfare proxies and the powers granted in the welfare and/or financial guardianships recorded on TRAKCare.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWIA 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. We found all patients had a section 47 certificate in place, with a comprehensive accompanying care plan.

For patients who had covert medication in place, all appropriate documentation was in order.

Rights and restrictions

Camus Tigh continued to operate a locked door, commensurate with the level of risk identified with the patient group.

On the day of our visit, two patients were on enhanced levels of observation; one patient had recently been placed on enhanced observation while the other patient had been subject to this for a longer period of time. There was evidence of regular review of the intervention. From review of the files, we were satisfied that the reasons for enhanced observation were proportionate to the risk assessment. However, we found the recording lacked a person-centred focus. We discussed with the CNM and SCN of the day of the visit that we would hope to see detail in the recording of enhanced observation that provided more holistic information about how the adult presented throughout the day. This level of detail would support the review process and ensure consistency of communication and care.

Camus Tigh had a seclusion room and seclusion procedures. In discussion with the SCN, we were made aware that the use of seclusion had reduced with the use of more therapeutic and continuous interventions being used to manage periods of stress and distress. Where patients still required this, we found detailed seclusion care plans, specifying clearly how the patient

was to be escorted to the room, how nurses were to engage with the patient during the period in the room, and the maximum period the patient was to be nursed in seclusion.

Our seclusion good practice guidance is available on our website at:

[Seclusion_GoodPracticeGuide_20191010.pdf \(mwcscot.org.uk\)](https://www.mwcscot.org.uk/Seclusion_GoodPracticeGuide_20191010.pdf)

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. None of the patients in Camus Tigh had an advance statement in their file. It was evident from meeting patients and reading their case records that the patients did not have the level of capacity required to make a valid advance statement. The Commission good practice guidance on advance statements is clear that the person making an advance statement, has to have the 'capacity of properly intending' the wishes specified in it. We discussed with the CNM and SCN that it remained important that any wishes or views the patients may have were considered when making decisions regarding care and treatment.

We heard from the CNM and SCN that advocacy support was readily available. Partners in Advocacy attend Camus Tigh regularly and we were pleased to hear that they have regular discussion with the MDT regarding how best to engage with patients to ensure the advocacy support is of benefit. Advocacy support patients who were subject to discharge planning and attended those meetings. Advocacy also attended CPA meetings.

The Commission has developed [Rights in Mind](#). This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:

<https://www.mwcscot.org.uk/law-and-rights/rights-mind>

Activity and occupation

Camus Tigh had a dedicated activities co-ordinator four days a week. The activities co-ordinator worked a pattern of weekdays and weekends to support activity and occupation throughout the week.

We heard the role of the activity co-ordinator was to develop individual activity planners for patients that included social, recreational and sensory activities. We were pleased to find an activity care plan in each patient's file that included a weekly programme of activities related to the patient's interests. We were pleased to see that the activities co-ordinator regularly recorded in case records. The records included personalised information, including what activity the patient had participated in and how they had responded during the activity.

The activities were split into one-to-one support sessions in the morning and a group activity (of two patients) in the afternoon. The activities included swimming, trampolining, sensory activities in the community, attending local garden centres/cafes, going to the park for a picnic and going on the barge. The unit had a dedicated minibus that was used most days. A maximum of two patients go on the bus at a time. The unit also had social activities at the weekend, such social evenings and takeaways that nursing staff arranged.

We heard and saw that activity care plans were reviewed regularly and that staff made attempts to provide patients with new activity opportunities. Staff engaged in discussion with

parents/carers to ascertain if the patients had any past interests or hobbies they participated in and enjoyed. We heard one patient had enjoyed horse riding in the past, so this had been arranged for the patient. At times, the patients do not respond well to new activities; however, we were pleased to see that staff were being proactive in providing the patients with diverse opportunities.

The physical environment

Camus Tigh was well maintained with an ongoing plan of re-decoration. We were told that the unit had been painted three months ago, however, it required regular repair due to damage caused by the patients. The SCN told us that the estates department respond quickly to repair requests, which was very helpful.

The entrance to the ward was bright and the environment was cleanliness was of a very high standard. There was artwork on the walls throughout, which promoted a sense of a warm and welcoming environment.

We were able to view most of the patient's bedrooms, and were pleased to see the level of personalisation, making their rooms as homely as possible. There were no en-suite facilities in Camus Tigh, although the bath, shower and toilet facilities were adequate.

There was a garden area that patients could access. The garden had a fence to ensure privacy for patients. There had been developments made to garden area that provided a pleasant, therapeutic and relaxing space for patients to enjoy. The garden was well maintained by St John's Hospital gardening service, as well as by community volunteers.

Summary of recommendations

Recommendation 1:

Managers should urgently review the psychology provision to the unit.

Good practice

We were impressed with the level of person-centred care for patients. We heard that one patient had recently celebrated a milestone birthday and there was another patient about to celebrate special birthday. The level of thought and planning nursing staff had put in to ensure these were special occasions for the patients was admirable.

We were also impressed by the significant detailed MDT approach to providing personalised care to patients in Camus Tigh.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report.

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 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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