Mental Welfare Commission for Scotland

Report on announced visit to: Glenlomond, Royal Edinburgh Hospital, Edinburgh, EH10 5HD

Date of visit: 24 April 2019

Where we visited

Glenlomond is a six-bedded locked forensic unit, based in the local community. It is a male only environment for patients who have a learning disability. We last visited this service on 15 February 2016 and made recommendations about case notes, the evaluation of patient care and the documentation that supported patient engagement in their care plans. We also commented on the need for improved recording in relation to physical health, restrictions placed upon patients, the environment, and the improvements that we thought were needed.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations and also look at future plans for the service. This is because we are aware that there are developments to relocate and redesign learning disability services in NHS Lothian.

Who we met with

We met with and or reviewed the care and treatment of all six patients who are currently in the unit. There were no relatives that wished to meet with us on the day of the visit, although a few of the patients that we met with had their advocacy worker present during the meeting.

We also spoke with the clinical nurse manager, the senior charge nurse (SCN) and members of the nursing team.

Commission visitors

Claire Lamza, Nursing Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We were able to meet all six of the patients in the unit, although levels of engagement varied in terms of hearing their views about the care and treatment they receive whilst in Glenlomond.

Of those that were able to talk to us at length, we were told that staff knew them well and were supportive. Patients were able to identify their key workers, and the associate nurses who worked with them on their care goals; they told us that they were involved in the decisions about their care, although they did not necessarily agree with some of these decisions. Those that we spoke to said that they could raise this with the staff who cared for them. We were told that staff are helpful and respectful. We heard that in some cases, where there were specific plans for care and treatment, that a consistent approach was not always used. We raised this with the SCN at the time of the visit.

Care Plans

We reviewed the care plans and found them to be detailed and extensive. Presently, all plans are paper-based, although we were advised that there is ongoing work to move to electronic records.

Each patient had two care files: one file with medical/legal documentation and assessments; the other with more current and active documentation, such as progress notes and care reviews. While we found the folders to be tidy and organised, with an index and sections detailing what documents were there, we found that there were earlier versions of documents that were no longer required or where the paperwork had been updated.

Previous recommendations had been to ensure that multidisciplinary records and care programme approach (CPA) minutes be filed in a timely way and that there was summative evaluation and review of the nursing care plans. We were pleased to see this has been actioned and found evidence of CPA meetings and of summative evaluation with the patient's treatment plans.

We also found that along with the CPA minutes, there was a separate sheet signed by the patient (where possible), along with an easy read version that covered all of the topics that were discussed. Terminology and language that was appropriate for this patient group was used and actions were detailed in short, easy to understand statements; we thought this was a useful documented that supported patient engagement and clearly noted the patient's views.

We noted that in the patients' care files there were variations in the level of personalised interventions associated with the treatment plans. In some we found that the objectives and associated procedures were person-centred and described what would happen specifically for that patient. For other treatment plans, generic terminology had been used, and in some cases, an inaccurate statement. We discussed these specific errors with the SCN on the day, although a more thorough audit of the care plans is required.

Recommendation 1:

Managers should ensure that there is a regular audit cycle to ensure that up-to-date and accurate, personalised information is recorded, and held in the patient's care and treatment plans.

We had also recommended that the annual physical health monitoring system should be reviewed. This had also been actioned and we were pleased to see that in all of the files that we reviewed, there was an up to date, fully completed physical health check. There was also a comprehensive health needs assessment, although in some patient's files, this should have been reviewed, and we found no evidence of this having been done. Where relevant, these assessments should be updated.

We found a range of other documents – detailed psychological assessments and functional analysis, multi-agency public protection arrangement (MAPPA) minutes, occupational/recreational/activity assessments and evaluations – where we could see the level of involvement, and treatment, that was available to patients in Glenlomond.

Use of mental health and incapacity legislation

All of the patients in the unit are managed under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). We found all of the paperwork relating to the detentions in the patients care files, although there were earlier versions of these that should be archived. All forms for consent to treatment under the Act (T2) and forms authorising treatment (T3) were available in the care plan and in the drug prescription sheet for the patient. All of the forms that we reviewed were in date and covered the prescribed medication.

At the time of our visit, consideration is being given to the use of the Adults with Incapacity (2000) Act for some of the patients in the unit. Presently, there are no welfare proxies, such as a welfare guardian, who have been appointed. However due to the future plans for moving patients on from Glenlomond, discussions have begun with the local authority in relation to the application process for welfare guardianships.

A previous recommendation was to ensure that the Responsible Medical Officer (RMO) should implement specified persons procedures. While we found copies of reasoned opinions in the patients care plans, they did not specify the reasons for the restrictions to be in place for each particular patient; the copies that we found were generic and non-specific. We also found that none of the forms covering the restrictions were up to date.

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 patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. We would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed and documented accordingly.

Our specified persons good practice guidance is available at:

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

Recommendation 2:

Managers must ensure that specified persons procedures are followed.

Rights and restrictions

We found that all patients in the unit, who had requested advocacy or legal advice, had access to these services. We met with advocacy workers who told us that they regularly supported patients at their care reviews and CPA meetings.

Access to and from the unit is via a locked door. There is a policy in place to explain why this is, and patients were aware of the restriction; staff are readily available to assist patients who are entering or leaving the building. Some of the patients require to be escorted in the community and this is clearly documented in their care plans.

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/rights-in-mind/

Activity and occupation

We were told that Glenlomond is a community-focused service, where there is a balance between the security needs of the patient group and the rehabilitation skills needed to move patients on.

Daily activities in the unit focus on patients maintaining their life skills. Patients are encouraged to make their own meals where possible, and at weekends, all patients in the unit are involved in meal preparation and in cooking. The patients are encouraged to attend to their personal care, including making sure that they attend the laundry. They also are encouraged to manage their finances.

We were pleased to hear about the frequency and broad range of activities for patients in Glenlomond. We were made aware that on a daily basis, every patient in the unit has an opportunity to go out. Several of the patients attended the day service at Columcille, and those that we spoke to were positive about this service and how important it was to them. We were also advised that there is involvement from independent sector services, who have input to the patients in Glenlomond.

In addition to the recreational activities such as art, music therapy, joinery, gardening, community outings, visits to family and holidays, there are also psychological and psychosocial groups available for patients. We heard about anger management, offending behaviour and trauma informed treatment programmes ran by psychology staff; again these were found to be helpful by those that we spoke to.

The physical environment

We were pleased to see that a previous recommendation about environmental issues had been fully actioned.

While we recognise that Glenlomond has been adapted for its current use, there are still difficulties in terms of access to the garden, which is only possible if going directly through the kitchen. The majority of the bedrooms are on the upper floor, with only one bedroom at ground level, which is the only room to have en suite access. During our visit, we were made aware that opening windows and having screens for windows, to ensure the privacy of the patients is an issue.

Recommendation 3:

Managers should address the issue of privacy and ventilation with windows in the building.

Any other comments

We were advised that the future plan for Glenlomond is that by 2020, the service will have closed. There have already been closures of other learning disability services, and staff have been redeployed to Glenlomond. We were informed that this has created some challenges, and raised these with the SCN and the CNM on the day of the visit.

Patients are aware of the unit's closure, and that alternative community placements are being developed. We were informed that while some patients have made their views clear about where they wish to reside, and who will be providing the care, there is ongoing discussion with the local authority, who will be jointly involved in overseeing the transition.

Summary of recommendations

1. Managers should ensure that there is a regular audit cycle to ensure that up-to-date and accurate, personalised information is recorded, and held in the patient's care and treatment plans.

2. Managers must ensure that specified persons procedures are followed.

3. Managers should address the issue of privacy and ventilation with windows in the building.

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.

ALISON THOMSON
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 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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