Mental Welfare Commission for Scotland

Report on announced visit to: Glenlomond, 37 Morningside Park, Edinburgh, EH10 5HD

Date of visit: 15 February 2016

Where we visited

Glenlomond is a seven bedded NHS unit providing care and treatment for male patients with learning disability and forensic issues, with or without concurrent mental illness. All the current patients are subject to detention under the Mental Health Act or Criminal Procedure (Scotland) Act.

There were six in-patients at the time of our visit. One bed is still open for a patient who has recently moved to the community on suspension of detention, where he is being supported by staff from Glenlomond.

We last visited Glenlomond on 14 January 2014 and made recommendations about:

- Specified persons procedures – we said that people should be made specified persons when this is required, and this should be kept under review and renewed if necessary.
- Environmental issues – we said that a number of environmental issues should be addressed.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with six patients.

We spoke with the senior charge nurse, charge nurse, other nursing staff and an independent patient advocate from Partners in Advocacy.

Commission visitors

Dr Mike Warwick, Medical Officer (visit coordinator)

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Patients we met made positive comments about staff and the support they receive from them.

Staff we spoke to were very knowledgeable about patients we discussed with them and how to support them.

One man we met, with an advocate, spoke of finding some staff very approachable and supportive. However, he expressed concerns about his perceptions of the attitudes of some other staff during interactions with him and other patients. We encouraged him to arrange a meeting with his advocate and the senior charge nurse

to tell her directly about his concerns. He agreed to do this, and his advocate said he would support him to do so. We informed the senior charge nurse broadly about the concerns he had raised about staff, and that we understood that he and his advocate would arrange a meeting with her.

Three patients we met mentioned having relationship difficulties with other patients in the house. We appreciate that this is a recurrent issue in Glenlomond, and that staff support patients to manage this.

Multidisciplinary team (MDT) input and documentation

A MDT meeting is held once weekly. This is attended by the Consultant Psychiatrist, nursing staff, forensic psychologist in training and mental health officer. Nursing staff write a useful weekly summary. Medical staff document a note of the meeting. The secretary takes a minute, which is typed and includes an attendance list. A paper copy of the minute is kept in a central folder on sheets that include more than one patient. However, staff do not file a copy in the patient's notes. We do not consider this to be good practice.

Regular Care Programme Approach (CPA) meetings are held for all individuals. This is good practice. Patients spoke to us about attending their CPAs. They have the support of their advocates to do so. For several patients, we could not find copies of the most recent CPA minutes filed in their case notes.

Organisation of case notes

Case notes were divided into separate medical, legal and nursing files. We found some notes hard to navigate, due to large volumes of historical information that could be filed elsewhere. We discussed this with the senior charge nurse.

Recommendation 1:

Managers should ensure that multidisciplinary team meeting records are filed in patients' case notes. Care programme approach minutes should be filed in good time after the meeting. Staff should remove historical documentation that is not relevant to current care from the working case notes.

Nursing care plans and risk assessments

Nursing staff had completed treatment plans and risk assessment and management plans for all patients. We consider that staff could add more individualised content to some care plans to more fully reflect person centred care they are providing e.g., for some patients, more information about how best to support and redirect them if they are distressed.

Treatment plans and risk management plans that staff had reviewed only had a review date recorded on them. Nurses make a "care plan review" record in their weekly summary, but we did not find that this contained the level of review of

individual care plans that we would expect. We advise that summative evaluation and review of individual care/treatment plans, including changes made, should be documented with the care plan in the notes. This might be done six monthly, or earlier if required.

Recommendation 2:

Managers should develop procedures for staff to undertake summative evaluation and review of individual nursing care plans.

Patient accessible Care Programme Approach care plans

When we last visited, patient accessible summaries of CPA care plans had recently been introduced. On this visit, one patient said he did not have one of these. Another showed us one from January 2014 and told us he had not had this updated since.

Recommendation 3:

Keyworkers should ensure that patient accessible Care Programme Approach care plans are kept updated in collaboration with the patient.

Psychology input

Several patients we met spoke positively about work they have undertaken with the clinical psychologist, including group work and anger management. We saw detailed clinical psychology reports in patients' case notes.

Annual physical health monitoring

Patients receive primary healthcare from Polwarth Surgery. Staff told us that all patients have had annual physical health reviews with their general practitioner (GP) within the last year.

The learning disability service has forms for physical health monitoring for nursing and medical staff to complete. We were informed that the GP completes the form entitled "annual review physical health monitoring". We wrote in our last visit report that this form did not include a prompt at the bottom for the doctor to enter their details and the date. This has still not been resolved.

We did not find these nursing and medical forms completed within the last year for some patients. The LD service annual physical examination form was not in use. We did see investigations filed. We did not see other routine documentation of the annual GP physical health reviews.

Recommendation 4:

Managers should review the annual physical health monitoring system and ensure that staff complete this. Senior medical staff should agree with the general

practitioner documentation of the GP annual physical health review to be routinely filed in the patient's case notes in Glenlomond.

Rights and restrictions

Room searches, need for use of specified persons procedures

Some patients have their rooms searched by staff for items they may have acquired that would be prejudicial to their health or safety or that of others. One man expressed dissatisfaction about this to us.

When the RMO has determined that room searches are required for this purpose, they should make the patient a specified person for safety and security in hospitals under s286 of the Mental Health Act. This is necessary to provide legislative authority for this restriction. It also provides the appropriate framework for review of the restrictions and the patient with their right to appeal against these.

We were concerned to find that none of these patients were specified persons, especially as we made a recommendation about this on our last visit. We discussed this with the senior charge nurse and the consultant psychiatrist, who had thought that room searches could be done under ward policy. The consultant had taken up post since our last visit. We have clarified the above with him.

Our specified persons good practice guidance is available on our website.

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

Recommendation 5:

The RMO should implement specified persons procedures for patients where this is required to authorise room searches or other restrictions.

Activity and occupation

Therapeutic activities

Nursing staff provide therapeutic activities within Glenlomond and escort patients on outings. Patients told us about activities they are engaged in and outings, and their enjoyment of these. Several people mentioned holidays past or planned. One man was particularly looking forward to going for a meal and to the theatre with staff that evening.

Some patients are escorted by nursing staff when attending therapeutic groups and activities elsewhere, including Marchhall (Learning Disability Service day service) and Columcille day centre. The Day and Recreational Therapy (DART) Team provide input including a weekly group activity alternating between dominos in the house and an outing to play pool (this session becomes a weekly sports session in the summer). Patients are involved in purchasing food and preparing meals.

One man does not have regular structured activities outwith Glenlomond, although he is engaged in activities within the house. He raised concerns about this with us. The Team can have difficulty allocating staff to escort him on outings during the day, although they make particular efforts to do so during evenings. We had discussion with the Senior Charge Nurse and his Consultant Psychiatrist. We have said that the service needs to allocate resources for this patient to engage in regular daytime activities outwith Glenlomond. We will follow this up.

The physical environment

Glenlomond is a period house and has a homely feel. Some patients showed us their bedrooms, which were personalised.

It is some years since Glenlomond was fully redecorated. We are concerned that the environment is, in most places, somewhat tired and in need of repainting. We noted throughout the house that some curtains were quite shabby. One was secured with drawing pins.

There are two rooms which we are particularly concerned about.

We consider that the downstairs shower room is in unacceptable condition. There is chronic discolouration from dampness high on the wall. In our last report we recommended that estates considered painting this area. On this visit we found stains on the wall as before. The senior charge nurse was unsure whether the wall was repainted since our last visit. She said the damp staining quickly returns after repainting. The wooden window frame was mouldy and dirty with paint flaked off the wood. Paint on the door was peeling and discoloured with mould. The flooring was discoloured and dirty at the edges.

In our last visit report we included a concern about the environment in one individual's bedroom. This remains ongoing, and is due to the patient's individual circumstances. In addition to the matter we previously raised, there was a large piece of wallpaper hanging off the wall which staff thought was due to damp. The room is an undignified environment for the patient to live in. We have written separately to the Clinical Services Development Manager about these matters.

Recommendation 6:

Managers should ensure that the following is undertaken:

- The wall in the downstairs shower room requires to treated as necessary to rectify recurrent damp/staining. Elsewhere, the room requires cleaned, refurbished as necessary, and painted.
- The environmental issues in the bedroom referred to in this report need to be addressed and rectified. The damp wall needs to be treated.
- Glenlomond needs to be redecorated, virtually throughout.

Summary of recommendations

Recommendation 1:

Managers should ensure that multidisciplinary team meeting records are filed in patients' case notes. Care programme approach minutes should be filed in good time after the meeting. Staff should remove historical documentation that is not relevant to current care from the working case notes.

Recommendation 2:

Managers should develop procedures for staff to undertake summative evaluation and review of individual nursing care plans.

Recommendation 3:

Keyworkers should ensure that patient accessible Care Programme Approach care plans are kept updated in collaboration with the patient.

Recommendation 4:

Managers should review the annual physical health monitoring system and ensure that staff complete this. Senior medical staff should agree with the General Practitioner documentation of the GP annual physical health review to be routinely filed in the patient's case notes in Glenlomond.

Recommendation 5:

The Responsible Medical Officer should implement specified persons procedures for patients where this is required to authorise room searches or other restrictions.

Recommendation 6:

Managers should ensure that the following is undertaken:

- The wall in the downstairs shower room requires to treated as necessary to rectify recurrent damp/staining. Elsewhere, the room requires fully cleaned, refurbished as necessary, and painted.
- The environmental issues in the bedroom referred to in this report need to be addressed and rectified. The damp wall needs to be treated. Glenlomond needs to be redecorated, virtually throughout.

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)

13/4/2016

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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk