Mental Welfare Commission for Scotland

Report on announced visit to: Waterloo Close, 2 Waterloo Close, Glasgow G66 3HL

Date of visit: 24 April 2017

Where we visited

Waterloo Close is a 4 bed unit situated in a residential area in Kirkintilloch. It is a bungalow style building accommodating four patients in single rooms, with communal dining and living spaces. It provides care and treatment for men with learning disabilities, additional mental illness and complex behaviour issues, who require or required a longer period of rehabilitation or treatment.

The 'Strategy for the Future' NHS GGC 2014 made a recommendation that the NHS should not be a long term provider, and that people should be supported to live independent lives outside of hospital settings, where possible. This aspiration was reinforced when guidance on hospital based complex clinical care was issued in May 2015, replacing guidance on NHS continuing healthcare contained in CEL26 (2008). NHS Greater Glasgow and Clyde strategic direction is in keeping with national policy for people with learning disabilities. This strategy applies to the two long stay units in NHS Greater Glasgow and Clyde, Waterloo Close and Netherton; both have hospital status, although neither are located on hospital sites.

Netherton and Waterloo Close, both with longer stay patients, are in the process of a resettlement and re-provisioning process that will lead to the closure of these two units; Waterloo is due to close by the end of summer 2017. The relevant Health and Social Care Partnerships have been coordinating the assessment of each person's needs and their suitability for placement in social care services. Joint assessment and future planning is ongoing for all the men residing in this service. Senior management have informed us that all of the people are clinically ready for discharge; they will remain in the service until a community package is developed which for some may take a number of months. On the day of our visit the four patients were in the unit, though not for the duration of our visit due to their engagement in activities.

We last visited this service on 3 September 2015. This was part of our national visits to learning disability inpatient units 2015. At that time, we identified some areas for improvement. An action plan was provided by the service, inclusive of steps they would be taking to address recommendations made on a local and national level. On the day of this visit we wanted to follow up on those areas identified for improvement within Waterloo Close. This included activity provision and recording. It was felt that more meaningful and frequent activities could be provided and that the recording of activity cancellations – including reasons for same – would help with monitoring. Concern had also been noted about the time it took to authorise and arrange for larger items to be purchased at Waterloo Close.

We visited on this occasion to see if there had been improvement in this area. We also wanted to give patients and carers an opportunity to raise any issues with us, particularly as we have been contacted by several families from Netherton and

Waterloo Close who are unhappy about the re-provisioning plans and are very concerned about the future for their relatives.

We also looked at:

- Care and treatment and carer participation
- Use of legislation
- Physical environment

Who we met with

We briefly interacted with each of the four patients and looked at the records of each of them. We also met with two sets of relatives.

We spoke with the senior charge nurse, the service manager, and a staff nurse. We had also spoken prior to the visit with the general manager to get an update on the current position with regard to re-provisioning of the service.

Commission visitors

Jamie Aarons, Social Work Officer

Kathleen Taylor, Engagement and Participation Officer (Carer)

What people told us and what we found

Care, treatment, support and participation

Our observations of interactions between patients and staff, and discussions had with nursing staff, indicate that staff know the patients well. Staff were observed engaging with several patients in informal games and art activities, before supporting them on an outing for lunch. Another patient was observed on the ward with staff on return from an outing with support workers. Transitional times like these can be difficult for some patients and it was noted that staff were adhering to guidelines to minimise risk and distress to the patient.

We were informed that across NHS Greater Glasgow and Clyde learning disability services, staff are working toward Accreditation for Inpatient Mental Health Services (AIMS) Standards through the Royal College of Psychiatrists. Progress being made toward this goal, including the compilation of service user and carer welcome packs, is being done within Waterloo and the manager advised of the intent to continue involving relatives in care planning and service development.

The relatives with whom we spoke were very positive about the care and treatment provided by the nursing staff. However, they were unhappy and concerned about the plans to re-provision the service and did not want the unit closed. They told us that patients concerned had a long history, over decades, of community and other

hospital placements. They felt that Waterloo has offered continuity and stability in the management of their relatives' challenging behaviour and complex mental health needs. They told us that they had confidence in Waterloo staff and believe that their loved ones continue to require specialist input to maintain quality of life.

Risk management plans were noted to be person-centred, thorough, and inclusive of explicit intervention strategies for staff to utilise to minimise risk. Care plans for physical healthcare needs are also thorough and person-centred. There was evidence that patients have had annual health checks and that any physical health concerns are addressed efficiently. We were pleased to see that a specific dementia-related care plan was created, when relevant, and staff were provided with training to deliver best outcomes for a patient. However, we did not find care plans to be outcome-focused and we felt that work could be done in this area to improve recognition of patients' strengths and abilities.

Weekly multidisciplinary team meetings include input from a range of allied health professionals, including psychology, occupational therapy, and physiotherapy. We were advised that pharmacy input is also regularly available and the pharmacist conducts a review on a fortnightly basis.

Overall, care files are inclusive of historical and, at times, contradictory information. For example, assessments with recommendations that have since been updated and revised were still contained in the file. This makes the files bulky and could lead to confusion or to the adherence of outdated guidelines; relevant information and intervention strategies can be difficult to find.

We were assured that patients who do not have regular family involvement have an advocate who can reflect their views, as far as possible, in the assessments for the re-provisioning process.

Recommendation 1:

The ward manager should ensure that care plans focus on individual needs and have clear outcomes. Care plan reviews should be meaningful, include the effectiveness of interventions, and reflect any changes in the individual's care needs.

Recommendation 2:

The ward manager should audit files to remove unnecessary and outdated information.

Use of mental health and incapacity legislation

We were pleased to find all consent to treatment (T2) and forms authorising treatment (T3) under the Mental Health Act (MHA) and s47 incapacity certificates and treatment plans under the Adults with Incapacity Act (AWI) were in place.

There are good personal spending plans for those patients whose funds are managed under Part 4 of the AWI Act. We saw efforts to encourage spending on appropriate items and think of ways patients could benefit from their money. This included use of patients' money to self-fund therapeutic activity on a weekly basis.

All documentation related to Specified Person restrictions were in order with reasoned opinions in the files.

Activity and occupation

The occupational therapy (OT) service at Waterloo has recently increased; the service now has OT input for three half-days per week. We were informed that there has been an increase in activities for patients generally, and it was evident through observation on the day of our visit that patients were engaged in informal activities on the ward and were going on outings. We were pleased to hear that there remain two unit vehicles to facilitate patient outings, in addition to some patient outings being facilitated by external providers who provide their own transport.

Although we observed patient participation in activity on the day of the visit, reference to patient participation in meaningful activity within the care file was difficult to find. We were assured by senior managers that improvements in relation to the detail of engagement, participation and desired outcomes is being developed within all services and all staff are encouraged to record in the care record.

We were pleased to see that several patients have been supported to self-fund particular on-site activities, including art therapy, music sessions, and aromatherapy. Relatives with whom we spoke were happy for their loved one to access these therapeutic activities through use of the patient's own funds.

The physical environment

We were pleased to see the ward is clean, bright and reasonably well maintained. The sitting room is comfortable and well furnished, though sparsely decorated due to some patients' tendencies to remove decorations from walls. Bedrooms are personalised to an extent, but are also sparsely decorated for the same reasons mentioned above.

The garden area is pleasant and spacious, though we were informed that it is rarely accessed by patients. It is a difficult space for patients with mobility problems to access due to uneven surfaces, but we felt that greater effort could be made to support patients to engage in activities within the garden.

Summary of recommendations

1. The ward manager should ensure that care plans focus on individual needs and have clear outcomes. Care plan reviews should be meaningful, include the effectiveness of interventions, and reflect any changes in the individuals' care needs.

2. The ward manager should audit files to remove unnecessary and outdated information.

Service response to report

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)

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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