Mental Welfare Commission for Scotland

Report on announced visit to: Blythswood House, Fulbar Lane, Renfrew, East Renfrewshire PA4 8NT

Date of visit: 10 April 2018

Where we visited

Blythswood House is a 15-bedded unit, divided into three five-bedded pods, with one self-contained flat attached. The unit provides assessment and treatment for adults who have a diagnosis of learning disability, mental illness and behavioural difficulties. We last visited this service on 28 February 2017. On this visit, we made recommendations relating to activities and the physical environment.

This service is part of the overall specialist learning disability inpatient provision for the NHS Greater Glasgow and Clyde area which is provided over two sites, Claythorn House and Blythswood House.

On the day of this visit, we wanted to follow up on the previous recommendations. We also wanted to look at how discharge planning was progressing for a number of patients whose discharge has been subject to significant delay whilst awaiting a suitable community resource to meet their needs on an ongoing basis.

Who we met with

We met with seven patients and reviewed the care and treatment of 15 patients. We did not meet with any relatives or carers on the day of the visit, but have spoken to two relatives in subsequent telephone calls.

We spoke with the service manager and the senior charge nurse. The charge nurse and the general manager joined the meeting at the end of our visit.

Commission visitors

Yvonne Bennett, Social Work Officer

Moira Healy, Social Work Officer

Kathleen Taylor, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

The unit, including the self-contained flat, was fully occupied on the day of the visit. In our discussions with a range of patients, they were positive about their care and treatment within Blythswood House and spoke highly of their relationships with the staff involved in their care, describing them as approachable, kind and very helpful. This was evidenced in the interactions we witnessed during the visit which were responsive and respectful.

We heard that multi-disciplinary meetings (MDTs) take place on a weekly basis and involve all the key staff involved in the individual's care. There is also a standing

invitation to patients and their relatives/carers/advocate to attend and participate in MDTs, and this varies according to personal preference.

Patients also have the opportunity to engage in regular one-to-one sessions with their named nurse which offered a further opportunity for a less formal discussion about their care and treatment plans.

There was evidence of good attention to physical health care, particularly in relation to learning disability specific health screening and more generic annual health checks.

We looked at all of the patients' care files. The files contain a vast range of information about each patient but were so large, that it was difficult to locate current, relevant and most recently reviewed care plans. This is partly due to the length of time some people have remained in the service. Staff advised that the service is moving towards electronic recording systems, but that a date for this to progress has not as yet been agreed. In the meantime, an audit of current case files should be undertaken to ensure that key information is easily accessed and the contents of the case files remain appropriate, relevant and are reviewed regularly.

Care plans and risk assessments were detailed and person centred but would benefit from a more robust and evidenced review process. We saw risk assessments that had been formulated on admission which did not appear to have been reviewed.

For patients whose discharge has been subject to lengthy delays, we felt that activity relating to discharge planning should be clearly recorded within the case file. We were advised of a range of reporting and monitoring arrangements which are in place at senior management levels, but felt that this should also be recorded for each individual patient so that the focus on discharge remains person centred and current. We were concerned that we saw instances where a resource had been identified as potentially suitable for an individual and, following a lengthy gap, being discounted, often with little explanation. Robust recording of these processes would assist in ensuring a focus on discharge was maintained and carried out within timescales agreed within the MDT.

Recommendation1:

Managers should carry out an audit of patient case files to ensure information they contain continues to be current, relevant and reviewed.

Recommendation 2:

Managers should ensure they monitor and record discharge planning activity for patients whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.

Use of mental health and incapacity legislation

On the day of our visit, all 16 patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and all legal documentation in relation to this

was up to date. Certificates authorising treatment (T3/T4) were in place authorising the prescription and administration of medication routinely, and in response to urgent need for treatment.

In relation to the Adults with Incapacity (Scotland) Act 2000 (AWI Act), almost all patients had s47 certificates in place to authorise physical health care. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act.

We noted that the content of these certificates were standard for all patients and we felt that, with the wide range of care needs evident, they could have been made more personal to each individual's needs. However, the information they contained was adequate and this observation was made only as a suggestion for ongoing development of the service.

A number of patients are subject to guardianship under the AWI Act and we heard that copies of the powers contained within an order are stored out with the patient file. This has led to some confusion in relation to what proxy decision making powers exist for individual patients and what powers had been delegated to nursing staff by the guardian. One patient was recorded as having a guardian in place and when this was explored further was an appointee for the purposes of managing benefits.

We felt that there was a need for training for staff in guardianship and greater clarity in recording of existing powers for individual patients.

Recommendation 3:

Managers should ensure that staff are suitably trained in the use of AWI legislation, and that copies of guardianship powers are included in individual case files to confirm the existence of a proxy decision maker and associated powers for the patient.

Rights and restrictions

All three pods within Blythswood House operate locked door policies due to the high levels of vulnerability among the patient population. Each patient has a comprehensive individual risk assessment relating to the level of support required within and out with the hospital.

There are good links with the local advocacy project who facilitate a regular community group meeting, as well as provide one-to-one support for patients as required.

Sections 281 to 286 of the MHA provide a framework within 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 Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Mental Welfare

Commission (MWC) would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Two patients on the day of our visit were specified persons and we saw a reasoned opinion for one of these in relation to these additional restrictions. Staff agreed to follow up on a reasoned opinion for the second adult.

Activity and occupation

We heard on our last visit that the role of activity nurse had been established and that this role would work closely with the occupational therapy department to ensure a wide range of therapeutic meaningful activities were available and delivered. We made a recommendation from this visit that clear records of participation in activities should be maintained.

On reviewing the case files, it remained difficult to ascertain the extent to which any individual patient had participated in activities, or indeed why this might not have happened. Although there was an individual planner in each of the case files, these at times contained entries we would not deem to be a meaningful activity, for example, long lie. They were often compiled some time ago with little evidence of how the patient had engaged in their planned activity and if the plan had been reviewed.

Where patients had been involved in music or art therapy, there was a clear record of how the patient had participated. We felt this model of recording could be extended further to ensure that activity levels for patients were adequate and tailored to patient need.

During the visit, we spoke to patients about their activities. No patients complained about a lack of activities, but none could report what activities they were involved in. Without an accurate record of involvement in meaningful activities it was difficult to gauge how effective this aspect of patient care was.

Recommendation 4:

Managers should implement a robust recording system to ensure appropriate levels of meaningful activity for individual patients.

The physical environment

Blythswood House offers bright well maintained accommodation in large single bedrooms with en-suite facilities. Patients are able to personalise their rooms and we saw comfortable and homely private spaces.

We were pleased to see that adjustments had been made to the fabric and use of the communal dining space, which has reduced noise levels dramatically, and created a less institutionalised communal space.

There is good access to secure outside garden space which is well used when weather permits.

The self-contained flat is a useful space which can be used to prepare for discharge, allowing care plans to be tested out, with the additional security of back up from nursing staff, if necessary.

Any other comments

Blythswood House is a facility which is designed to deliver an assessment and treatment facility for adults with a diagnosis of learning disability, mental illness and behavioural difficulties. At present there are six patients who are deemed fit for discharge but whose discharge from hospital has been delayed, in some instances for a number of years, due to a lack of suitable community resources to meet their needs on an ongoing basis. At the same time, patients are being admitted whose care needs are in relation to an acute presentation of illness. At times this combination of diverse need can present significant challenges to the service.

We will seek an update on discharge planning from the responsible Health and Social Care Partnerships.

The service is currently undergoing a process of redesign supported by the National Development Team for Inclusion. This process is in its early stages and we will be interested to see how this develops to ensure the service remains able to respond to changing and evolving need.

Summary of recommendations

1. Managers should carry out an audit of patient case files to ensure information they contain continues to be current, relevant and reviewed.

2. Managers should ensure they monitor and record discharge planning activity for patients whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.

3. Managers should ensure that staff are suitably trained in the use of AWI legislation and that copies of guardianship powers are included in individual case files to confirm the existence of a proxy decision maker for the patient.

4. Managers should implement a robust recording system to ensure appropriate levels of meaningful activity for individual patients.

Good practice

During the visit we heard how Blythswood House are committed to ensuring meaningful patient and carer involvement and the activity they have initiated to maximise for this involvement. One example of this is the recent involvement of

relatives/carers in reviewing the unit's Zero Tolerance Policy and how this has resulted in a number of changes. We are interested to see how this develops.

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 Inspectorate 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 oftenwe 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