



Mental Welfare Commission for Scotland

Report on announced visit to:

Islay Centre, Royal Edinburgh Hospital, Morningside Terrace,
Edinburgh, EH10 5HF

Date of visit: 12 September 2017

Where we visited

The Islay Centre is the service name for three units, with a total of 11 individual areas, with one of these areas designated for use by the Child and Adolescent Mental Health and Learning Disability team (CAMH-LD team). The service currently provides assessment and treatment for males who have a learning disability, who have significantly complex and challenging behaviours, often associated with a diagnosis of autistic spectrum disorder. The three units, which are all accessed separately, are:

Harris, which can accommodate three patients. Barra, which can accommodate four patients, and Rhum which can accommodate three patients plus accommodate a patient managed by the CAMH-LD team.

Presently, all 11 individual areas are accommodating patients who are managed by the Islay Centre. In addition, the West Wing in Carnethy House is also being used by a patient who is managed by the Islay Centre.

The multi-disciplinary team (MDT) consists of medical/psychiatry, nursing, psychology, occupational therapy (OT) and speech and language therapy (SALT) that provide input into the care of the patients.

This was an announced visit. Our last visit to the service was on the 20th January 2015 as part of the 'No Through Road: People with Learning Disabilities in hospital' report, published in February 2016.

At that time, we made recommendations in relation to reviewing the use of the seclusion room, the evaluation and review of nursing care plans, the development of patient accessible care plans, undertaking duties for cross border transfer visits in a timely manner, the implementation of specified persons procedures in accordance with the Mental Health Act and for environmental issues to be addressed. We received a satisfactory response to these recommendations in June 2015.

On this occasion we visited to review and observe the type of care offered to patients who are in all three units of the Islay Centre, as well as Carnethy House. Due to the needs of this group, meeting directly with patients was not always possible, but where this could take place, we were able to ask about their care and treatment. We were able to meet with relatives that had agreed to speak with us, as well as talking to members of the MDT. We were interested to review the following areas specifically:

- Care planning
- Use of legislation
- Physical environment
- Activities.

Who we met with

We had varying levels of contact with four patients on the day, met with three carers, spoke to 10 members of staff and looked at nine sets of records. We also met with the senior charge nurse (SCN), the clinical nurse manager (CNM), the consultant psychiatrist/clinical lead, the specialist trainee, the speech and language therapist and the occupational therapist.

Commission visitors

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

Graham Morgan, Engagement and Participation Officer (Lived Experience)

Douglas Seath, Nursing Officer

What people told us and what we found?

Care, treatment, support and participation

We found that the care delivered across the units was person-centred and tailored specifically to meet the needs of each patient. We found detailed treatment plans, risk assessments, management plans and a file that contained any legal paperwork. The files contained historical and current information. We asked about how the information in the files is used to support daily practice, and were advised that the treatment plan folders are used when new staff 'shadow' the staff who have been delivering care for a longer period of time.

What we did find in the care plans is that while there are a range of useful documents (detailed interventions in treatment plans, positive behavioural support plans, patient accessible care plans using pictures and signs, a record of staff escorted activities and individual timetables) these were not always up to date.

Recommendation 1:

Managers/leads for the service should develop and implement a care plan audit system that identifies key documents for routine review.

When we met with the CNM and the SCN, we discussed some of the recent staffing issues. Individualised care across the units of the Islay Centre depends on a higher nurse to patient ratio than would be found in other clinical areas. This is to ensure that the care provided for this particular group of patients can be structured in terms of one to one, two to one, or in some cases, three to one interactions.

Lately, constraints in terms of nursing staff absence and vacancies have meant that the amount of dedicated time that a patient has with nursing staff has reduced.

However, we were informed that the recent recruitment of nurses will address this issue.

In terms of the treatment provided for those in the Islay Centre, we found that the care team's specialist knowledge and skill in working with the very specific needs of this group has brought about positive changes, especially with some patients. We were impressed with the commitment and dedication of staff. The feedback from some of the relatives we spoke to indicated that they recognised that the team were making a difference with some of the patients' very challenging behaviours. We were made aware that in the next financial year there will be a community based service developed, which would be appropriate for some of those patients in the Islay Centre to move on to.

We appreciate that services for patients with learning disabilities and autism, including the Islay Centre, are continuing to develop and we recognise that the staff and the service has an established level of specialist knowledge in this field. We discussed and agreed that a philosophy and operational policy of the unit would help inform the current users and carers about the service, as well as those who access or request information about the Islay Centre in the future.

Recommendation 2:

Managers/leads for the service should develop a local policy that informs all relevant patients of the care and treatment objectives and goals for the unit.

Use of mental health and incapacity legislation

For the patients we met with and reviewed, all were cared for under either Mental Health Act (MHA) and/or Adults with Incapacity (AWI) legislation. We noted that there is access to advocacy, and where the patient wished this, advocacy were actively involved.

We found the documentation for those who were detained under the MHA up to date. However, for those who were under welfare guardianship, we were unable to find a copy of this document in some of the patients' notes we reviewed.

We also noted that in some instances, where a certificate authorising treatment (T3) was in place, there were a number of these that needed to be updated. The MWC advises that these are renewed every three years. We were told that MDT meetings are held in an area in the Islay Centre away from the care plans and clinical records. We discussed how the MDT could access each patient's relevant documentation to ensure that the legislative paperwork is kept up to date; the MDT members will take this forward.

Recommendation 3:

Clinical lead/SCN should promptly review all patients' legal documentation in their care plans to ensure that they have up to date records of MHA and AWI forms as required.

Rights and restrictions

Due to the needs of the patients who are in the different units of the Islay Centre, the use of seclusion, restraint and restrictions of access to specific items takes place regularly.

There is ongoing work in terms of staff understanding and recording of the different types of monitoring when seclusion and restraint occur. This is also happening with patients to assist them in identifying times and ways in which they can have 'self-directed activity', where they can opt to carry out activities of their own choosing.

We note that for some patients, their personal preference is to have their door locked, and this is documented in the care plan, with detailed interventions about what happens in this situation. We were provided with a copy of the recently developed Seclusion and Restraint Recording chart, which also notes when there is a service pressure temporary restraint (locked door), and will be able to use this to review the frequency of this at future visits.

We found that there is a very clear recording of the use of seclusion. While there was a defined amount of time that seclusion could be used, the records we reviewed noted that it was not used to the full extent.

Specified persons provision had been raised in our last report in 2015 and we found on this visit that staff were conducting room searches where there was no RES1 form noted in the care plan; the staff were also uncertain about the need for this part of the legislation and were referred to the MWC guidance.

Recommendation 4:

SCN/DCNs to develop and implement training for nursing staff on the use of specified persons

Recommendation 5:

Clinical lead should review all patients to ensure that appropriate RES1 and RES3 forms (where applicable) are in care plans.

The physical environment

Of the patients we met with and reviewed, we noted that they have spacious, private areas for their own care. The suites function as multi-purpose areas i.e. patients eat, sleep, and have their social/recreational activities provided for in their rooms, which are en-suite. For one patient, the space is large enough to accommodate different

activities, such as eating in one room, sleeping in another and access to a large 'safe' area which again is separate. We found some rooms furnished with sofas, storage units filled with personal items, TVs, as well as beds, tables and chairs; in others, the rooms were sparse with very few items. However, in those situations, we were aware that this was because the patients themselves chose to have their own areas in this way. Each patient has access to their own garden/outside space area.

We observed that where the patient wished it, their environment was as personalised as it could be and that staff, families and carers would promote this to the greatest extent possible. We would encourage other creative options to be considered which may reduce the sparseness of some environments, but that do not increase the risk of harm or distress.

Activity and occupation

The day to day routines for each patient is set around a timetable, and the needs of this group mean that having a structured, consistent routine reduces stressed and distressed behaviours. Of those we reviewed, the level and type of activities varied; some patients spent extended periods of time in their rooms, others had a timetable where community activities were all regular occurrences. We found that there was creative thinking where there were concerns around safety; the use of "messy play", baking, ball play and other activities ensured that those patients could still engage with staff, even when distressed.

We were aware that some timetables required updating and this should be actioned promptly, as noted in Recommendation 1.

We noted that the minibus that is shared between the three units and Carnethy House is very well used and in the case of the patient currently in the West Wing of Carnethy House, this is a core part of their daily routine and one that has the most significant impact. We were pleased to note that staff facilitated this patient accessing daily activities in the minibus.

Staff told us that there used to be two vehicles that they could access and having only one has restricted their opportunities to take more patients out. This was raised on a previous visit and we would ask again if this could be considered to increase the opportunity for community based patient activities.

Recommendation 6:

Service managers should review options that would enable staff access to vehicles, to facilitate an increase in community based activities.

We were impressed with the active engagement and work that has been undertaken by OT and SALT. Their contact with patients has supported positive change; their assessments and input into the direct care of patients is beneficial in supporting their nursing colleagues, especially in the case of one particular patient who has their own

dedicated team of staff. We recognise the value of direct intervention from all MDT members and would encourage this approach throughout all of the units, to progress the range of structured activities that address physical, psychological, and social/recreational needs.

Any other comments

We were told of further developments planned in terms of supporting nursing staff, specifically around protective clothing, using safety huddles/briefings to improve communication and a review of shift patterns. It is hoped that these, along with the newly recruited staff, will support the development of systems and process, such as clinical supervision, and encourage nurses in the units to feel more involved and engaged.

Summary of recommendations

1. Managers/leads for the service should develop and implement a care plan audit system that identifies key documents for routine review.
2. Managers/leads for the service should develop a local policy that informs all relevant patients of the care and treatment objectives and goals for the unit.
3. Clinical lead/SCN should promptly review all patients' legal documentation in their care plans to ensure that they have up to date records of MHA and AWI forms as required
4. SCN/DCNs to develop and implement training for nursing staff on the use of specified persons.
5. Clinical lead should review all patients to ensure that appropriate RES1 and RES3 forms (where applicable) are in care plans.
6. Service managers should review options that would enable staff access to vehicles, to facilitate an increase in community based activities.

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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