Mental Welfare Commission for Scotland

Report on an announced visit to:

Blythswood House, Fulbar Lane, Renfrew, Renfrewshire PA4 8NT

Date of visit: 28 February 2017

Where we visited

Blythswood House is a 15-bedded inpatient facility with one self-contained flat attached, which is currently unoccupied and being refurbished. It provides assessment and treatment for adults with a learning disability, mental illness and behavioural difficulties. We last visited this service on a local visit on 28 April 2015 and at this visit we raised concerns about the physical environment.

We also visited as part of a national themed visit to learning disability inpatient services on 6 October 2015 which resulted in our report 'No Through Road'.

On the day of this visit we wanted to follow up on the previous concern about the environment and give patients and relatives the opportunity to raise any issues with us.

Who we met with

We met with two relatives and reviewed the care and treatment of seven patients.

We spoke with the service manager, the senior charge nurse and other clinical staff including medical staff at the end of day meeting.

Commission visitors

Susan Tait, Nursing Officer

Alison Goodwin, Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We observed supportive and respectful interactions between patients and staff during the visit, and, where individuals were able to give us their view, they indicated positive relationships with staff. This included the two relatives we spoke to.

Risk assessments and care plans identified clear goals and interventions and were individualised. There was evidence of review, however, this was in the form of a signature and date at the bottom of the care plan. It would be helpful to have a separate entry which showed that the care plan had been reviewed.

There was good attention to physical health care, in particular learning disability specific health screening and annual health checks. There was good input from a multidisciplinary group (MDT), including psychology, occupational therapy (OT), speech and language therapy (SALT), dietician, physiotherapy and psychiatry.

There are regular MDT reviews of care and treatment and decisions are clearly documented. It was good to note that clear and detailed nursing assessments were recorded in order to inform the care plans.

We were told that at present there are six patients whose discharge is delayed; this has been the case for some time and has not improved since our last visit in 2016.

There were specific concerns raised by staff about working collaboratively with Health and Social Care Partnerships, particularly in the development of new services for people who are ready to be discharged.

We will be writing to senior managers for further information about the patients whose discharge is delayed and the sharing of information across the partnership.

Use of mental health and incapacity legislation

Nearly all patients were detained under the Mental Health Act (MHA) and necessary documentation in relation to this was in place. All patients had s47 Adults with Incapacity Act (AWI) certificates to authorise physical health care. There was one certificate which had been completed on an out of date certificate which did not authorise the treatment being given. This was raised with the clinician on the day and was rectified. Certificates authorising treatment (T3) were in place to authorise the prescription and administration of medication as appropriate. Where individuals were subject to welfare guardianship, copies of the guardianship document were accessible within patient files.

Rights and restrictions

All patients had access to advocacy and the advocacy service also organise the collective advocacy group which feeds back any concerns to staff and managers.

Activity and occupation

All patients had an activity planner with a range of activities relative to their interests and requirements and evidence of occupational therapy input. A nursing assistant had been given the role of activities nurse, however, they were often diverted from that role to provide clinical support, in particular where patients were subject to constant observations. This was having an impact on the range and availability of therapeutic activities for individuals as they often had to be cancelled. It was not easy to see at a glance the level of participation of each patient in meaningful activities as these were recorded in different documents. It would be useful to record when and for what reasons activities are cancelled so this can be monitored.

Recommendation 1:

The manager should review the role of the activity nurse to ensure that it is not subsumed into other clinical needs.

Recommendation 2:

The manager should ensure there is a clear record of participation in activities for each patient and reasons for lack of participation or cancellation of activities are audited.

The physical environment

The environment is configured into three pods providing care for five patients in each pod. All individuals have their own bedroom which we were pleased to see were individualised. The main issue for the environment is the communal dining area which is unsuitable for the patient group: many are on the autistic spectrum and are likely to have hypersensitivity to sound. Some measures are in place to mitigate the negative impact but a specialist OT sensory assessment of the dining room should be carried out. This was the recommendation from our visit in 2015, and has been highlighted in previous reports. We will therefore now direct this recommendation to senior managers.

Recommendation 3:

The manager should arrange for a specialist OT sensory assessment of the dining room and act on the recommendations from this assessment.

Summary of recommendations

1. The manager should review the role of the activity nurse to ensure that it is not subsumed into other clinical needs.

2. The manager should ensure there is a clear record of participation in activities for each patient and the reasons for lack of participation or cancellation of activities are audited.

3. The manager should arrange for a specialist OT sensory assessment of the dining room and act on the recommendations from this assessment.

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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