

Mental Welfare Commission for Scotland

Report on announced visit to: Camus Tigh, Kirkhill Road, Broxburn
EH52 6HT

Date of visit: 17 January 2017

Where we visited

Camus Tigh is a seven bedded NHS unit for male patients whose behaviours challenge services due to a diagnosis of learning disability and complex care needs. We last visited this service on 29 July 2015 as part of a national themed visit to learning disability inpatient units, and recommended that the service review and improve care files, care/treatment plans and risk assessment/management plans. Physical health checks for some patients were not up-to-date. We raised some issues with the environment including under use of the garden.

On the day of this visit we wanted to follow up on these matters.

Who we met with

We met with and/or reviewed the care and treatment of six patients. We spoke with the unit charge nurse and the clinical services development manager.

Commission visitors

David Barclay, Nursing Officer

Dr Mike Warwick, Medical Officer

Dr Unoma Okudo, Attached Specialist Trainee Psychiatrist

What people told us and what we found

Care, treatment, support and participation

On the day of the visit we met with the relatives of three patients. They all spoke positively about the care and treatment provided at Camus Tigh. Mention was made of the availability of staff and how they felt fully involved and informed of all the treatment decisions that were being made. We were told that the nursing staff all have a good knowledge of the patients and the carers were happy with this. There was feedback from one family who said that the staff had managed to create a calming atmosphere that reduced the incidence of distressed behaviour, and that this had a noticeable beneficial impact on their relative since he moved there. We saw that patients were relaxed in the unit, many were involved in activities on site and outside with staff from DART (Day and Recreational Activity Team) and Marchhall Day Centre.

Individual care/treatment plans were thorough, person centred and recovery focused. It was clear that the care plan information within was based on the risk assessment and management plan. In some cases there was repetition of content between some risk management plans, care plans and between care plans. We suggest that reviews of care plans are undertaken to consolidate information where appropriate.

An update in relation to care plans is compiled by nursing staff on a weekly basis for the multidisciplinary team (MDT) review meeting. Staff periodically review care plans and update them if indicated. However, they do not specifically document this review. We consider that staff should record their review of the care plan, including evaluation of the effectiveness of the interventions and any changes they make to ensure that the care plan meets changing needs.

The weekly MDT meeting was usually only attended by the consultant psychiatrists and charge nurse or senior charge nurse. We were informed that other members of the nursing team now attend these meetings. This enables them to be more directly involved in clinical reviews. The nurses complete an update pro-forma for the meeting and medical staff make a note entry. This does not always include an attendance list. Staff should ensure that an attendance list is documented.

Some work has been done to streamline files. However, we still had difficulty navigating case files and locating information, particularly in medical notes. Many files were voluminous as patients have been in hospital for much of their lives. Managers should arrange for files to be organised to contain current working documentation information, with dividers between sections.

The MDT undertake an annual review for each individual when their responsible medical officer (RMO) reviews their need for detention under the Mental Health Act. Medical staff document this in the medical notes. There is no process for creating a typed record of this review. We consider that staff should have the resources they need for this to be done.

Recommendation 1:

Managers should audit care plans and ensure that nursing staff document periodic review and evaluation of individual care/treatment plans.

Local GPs provide medical physical healthcare for patients. Annual physical health checks had been undertaken for all patients by the associate specialist in consultation with the GP on a local pro-forma. A review of annual physical health monitoring across the NHS Lothian learning disability service is currently being undertaken.

Use of mental health and incapacity legislation

In three of the files we reviewed, we noted that there were no paper copies of the current Mental Health (Care & Treatment) (Scotland) Act (the Act) detention documentation. We were informed that this was due to all detention paperwork now being stored electronically on the Trak care system, although Camus Tigh has not yet been connected to this system. Paper copies of the current detention documents arrived on the unit prior to our departure.

All patients that required T2 and T3 consent to treatment forms had them, and they were stored with the prescription sheets and fully covered the psychotropic medication prescribed.

Recommendation 2:

Managers should ensure that current detention documentation under the Act is accessible to staff caring for detained patients.

Adults with Incapacity (Scotland) Act 2000 s47 certificates

Section 47 certificates/treatment plans were in place and covered medications and treatment that patients were not capable of consenting to. We were pleased to see that generally this was being done well.

However, one patient had an intervention for management of disturbed behaviour which was authorised by their Compulsory Treatment Order. Treatment authorised under the Act should not be included on a s47 certificate/treatment plan.

Covert Medication

Some patients required the use of covert medication. Mental Welfare Commission covert medication care pathways were in place and were regularly reviewed. However, the covert medication pathway used was not the current version, which includes a section for the method of covert administration of each medication. It would be good practice to use the new pathway.

One patient was being given a medication covertly with food that was not included in their pathway. We did not see a record of consultation with a pharmacist about this, and recommended to the charge nurse that this should be done.

The Commission's good practice guidance on covert medication and pathway pro forma are available on our website:

<http://www.mwscot.org.uk/publications/good-practice-guides/>

Rights and restrictions

The unit is locked and we were pleased to see the unit locked door policy on display at the front door in an easy read format. Patients can get outside with unit staff support or with DART or Marchhall staff. Camus Tigh is a no smoking unit, though this does not affect any of the current patients.

Use of Seclusion

We reviewed the use of seclusion in the unit, the care plans and associated records were in place and generally followed recognised good practice.

We had discussion with the clinical services development manager and charge nurse on the day about some aspects of seclusion care plans that could be made clearer. We recommended that staff should specifically document offering toileting and fluids during seclusion on the individual's seclusion observation record.

The physical environment

Internally the unit was clean, pleasingly decorated and patients' rooms and doors were personalised. There were easy read signs to show where bathroom, toilets and sitting/dining areas were located. We were pleased to see that the kitchen had recently been upgraded to a very high standard. One bathroom was able to be used appropriately but there was another that could not be used by patients in that part of the unit as the bath presented a falls risk. Two of the toilets we viewed required upgrading, one had a rusting radiator while the other had damage to the flooring. The key operated locks in the unit were noted to be a problem and this was an issue that had been reported as a priority to the estates department.

Externally, we considered that the wood around the roofline and windows would benefit from repainting. One of the exterior doors had water damage that required repair or replacement.

Recommendation 3:

Managers should ensure that locks are replaced, the external damage to the quiet room door is repaired, and the need for external painting is reviewed.

Garden Area

The large enclosed garden area remains underutilised, this seems to be a waste of a valuable resource. There was a pergola sitting area but this was being used to store old condemned sofas awaiting removal from the site. One patient's family had purchased some garden furniture that he used during the summer months, this did create a fairly pleasant personalised small area in the garden.

Recommendation 4:

Managers should ensure that the garden area is upgraded to provide a safe, welcoming, and easily accessible area for patients and visitors.

Activity and occupation

There were activity care plans for all patients reviewed and these were regularly updated. The relatives we spoke with commented that patients are very active and engaged in activities that are suited to their interests. There was a board in the corridor which indicated pictorially what each person was doing on a particular day.

Staff commented that occasionally outside staff had to cancel activities but that unit staff prioritised activities and replaced these where possible. There was a minibus used for the benefit of patients

Any other comments

It is worth noting that the unit is currently going through considerable staffing changes. It is clear that they know the patients and the patients' families well. The ethos of the unit promotes a calm, caring and homely environment.

Summary of recommendations

1. Managers should audit care plans and ensure that nursing staff document periodic review and evaluation of individual care/treatment plans.
2. Managers should ensure that current Mental Health Act detention documentation is accessible to staff caring for detained patients.
3. Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable.
4. Managers should ensure that the garden area is upgraded to provide a safe, pleasant, and easily accessible area for patients and visitors.

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

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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