



Mental Welfare Commission for Scotland

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

Date of visit: 26 September 2018

Where we visited

Camus Tigh is part of NHS Lothian's learning disability (LD) service. It is located in a local community in West Lothian. The unit's capacity is for seven patients but there are plans to reduce this to six. Presently, there are seven patients in Camus Tigh, although one patient was awaiting community placement.

The patients in the service had a primary diagnosis of learning disability, and had complex care needs.

We last visited this service on the 17 January 2017 and made recommendations relating to care plan audits and the documentation of reviews and evaluation, accessible paperwork, and repairs and upgrading of the physical environment.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the care and treatment of any patients in the unit with Autistic Spectrum Disorder (ASD). This is because the Commission is presently undertaking a themed visit to this group.

Who we met with

We met with, and reviewed the care and treatment of, all seven patients in the unit. We also had contact with two carers prior to the visit.

We spoke with the senior charge nurse (SCN) and the clinical nurse manager (CNM), as well as members of the nursing team who were on duty on the day of our visit.

Commission visitors

Claire Lamza, Nursing Officer

Ian Cairns, Social Work Officer

Colin McKay, Chief Executive

What people told us and what we found

Care, treatment, support and participation

The relatives that were in contact with us prior to the visit told us that they considered the day-to-day care to be excellent. They told us they were pleased with the efforts made by staff to support engagement and participation which they felt had benefitted the member of their family, and that their stay in Camus Tigh had been of benefit to them.

Concerns were raised about the possible closure of the unit, and recognition that adequate staffing levels are needed to maintain the current level of care. Both these points were discussed with the SCN and the CNM during our visit.

We were advised that future plans were for Camus Tigh to move to the Royal Edinburgh Hospital alongside other LD services. In keeping with the move, there were proposals to reduce the number of beds in the current unit. At our visit we were told that a seventh patient had been moved to Camus Tigh due to bed pressures in the other LD services. There were other patients in the unit whose discharges were also delayed.

We recognise that delayed discharges are a challenge for clinical services and understand that NHS Boards have systems in place to monitor this. However, evidence in the patients care plans, about actions that were being taken to address the delay, was not clear.

In addition to the nursing team, there is a consultant psychiatrist, a dietician, physiotherapy, psychology, and occupational therapy. All patients are registered at the local GP practice, and were referred there for any physical healthcare needs.

We met with the patients whose care we reviewed and used the care plans and the documented information to review what was being provided, and also observed interactions between the staff and patients.

On the day of our visit, we found staff to be skilled in meeting the needs of a patient who appeared to be distressed. However, this resulted in privacy and dignity concerns for other patients in the main day area of the unit which we addressed on the day with the SCN and CNM.

Recommendation 1:

Managers should clearly identify where there is a delay in discharge and the actions being taken to address this.

Recommendation 2:

Managers should review the observation policy in the unit to ensure that the dignity and safety of all patients is maintained.

Care Plans

On our last visit, we recommended that care plans should be reviewed and audited. Camus Tigh is moving to an electronic patient record system, although paper-based care plans hold the assessments, treatment plans, and reviews. Working between the two systems is difficult when trying to find key information.

We found that care plans contained comprehensive assessments and were written with a clear person-centred focus. There was a broad range of assessments and detailed treatment plans including physical, emotional, behavioural, and social care needs. There was good use of the green, amber, red traffic light system, with information about identified triggers and pro-active and reactive strategies.

We found evidence of reviews. There were Care Programme Approach (CPA) minutes and specific actions set out in the files. We noted that previous actions for specific professionals that had been agreed at the earlier CPAs had been carried out. There was evidence in most files of multidisciplinary input, with specific reports from occupational and speech and language therapists.

In some files we found no evidence of an annual review or updates on contact with clinical staff who were actively involved. There were also different formats being used for documents that had the same purpose, and old documentation that could have been archived.

There were some care plans that were well organised and up to date and we would recommend that these be used as the exemplar for all other files.

Recommendation 3:

Managers should ensure that a standardised approach and consistent recording is used in all files and regularly audited.

Use of mental health and incapacity legislation

In some records, the electronic system (TrakCare) held copies of paperwork for those patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) but some were kept as a paper version in individual files. This made it difficult to locate the MHA paperwork for some patients.

Where patients were subject to the MHA, we found that medication was administered with required certificates to authorise treatment (T3s). However, we found some T3 forms that were over three years old. While there is no time limit defined in the MHA for T3 forms, the Commission advises that these are renewed every three years.

We were able to review copies of welfare proxies (guardianship orders and powers of attorney) under the Adults with Incapacity (Scotland) Act 2000 (AWI) in the care plans. There were also certificates where patients did not have capacity in relation to decisions about medical treatment, completed under s47 of AWI. The s47 certificates that were in place had accompanying treatment plans.

Some patients required the use of a covert medication pathway, and the Commission pathway had been used for any medications that were being administered covertly.

Recommendation 4:

Managers should ensure that all T3 forms are renewed no less than every three years.

Rights and restrictions

Access in and out of the building was via locked doors, and there is a local policy to support this. Patients who wish to go outside of the unit are escorted, but while they were in the unit they had open access to their rooms and the main day areas.

Where requested, we noted that patients had been able to access advocacy and legal representation.

We looked at the seclusion room and seclusion procedures and noted that our previous recommendation had been completed. In discussion with the SCN, we were made aware that the use of seclusion has reduced. Where patients still required this, we found detailed protocols for the use of seclusion, specifying clearly how the patient was to be escorted to the room, how nurses were to engage with the patient during the period in the room, and the maximum period the patient was to be nursed in seclusion.

The Commission has developed [*Rights in Mind*](#). This pathway is designed to help staff in ensure that patients have their human rights respected at key points in their treatment.

This can be found at <https://www.mwcscot.org.uk/rights-in-mind/>

Activity and occupation

The frequency and range of activities available for patients had been maintained since our last visit. We found meaningful activity provided for patients, supported by both staff in the unit and for those attending Newington Day Hospital or March Hall.

We found activity planners in patient files, as well as an easy-to-read board in the main area. The minibus continued to be well used for accessing local community resources and, where possible, patients are supported to have outings that include their family.

We found that outings take place for some on a daily basis, but that there are also morning and/or afternoon sessions in the unit. There was a focus on sensory sessions (e.g. music, food, and the sensory box) as well as tailored activities such as trampolining, photography, and visits to local places of interest.

The physical environment

We note that the previous recommendations regarding the environment had been actioned. In the main living room we saw that opaque screening had been used on parts of the window to protect the privacy of patients, while still enabling patients to look out. There is some artwork on the walls, and easy-to-read signs for bathroom/toilet areas. We thought that the use of a housekeeper, who shops for and prepares specific meals to suit the patient's needs, was a particular benefit.

We were pleased to see the level of personalisation in patients' bedrooms, where it was evident that creative use of finances had helped design spaces that patients could enjoy.

This continued into the garden area where there has been visible progress. The external fence had been increased to ensure greater privacy for patients and there were designated areas for sitting, for relaxing and for playing games. There were tables and chairs to sit at, some colourful beanbags for relaxing in, and a large garden swing which patients can access. We were told that there are future plans to develop the garden area further.

Summary of recommendations

1. Managers should clearly identify where there is a delay in discharge and the actions being taken to address this.
2. Managers should review the observation policy in the unit to ensure that the dignity and safety of all patients is maintained.
3. Managers should ensure that a standardised approach and consistent recording is used in all files and regularly audited.
4. Managers should ensure that all T3 forms are renewed no less than every three years.

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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

