

Mental Welfare Commission for Scotland

Report on announced visit to: Kylepark Cottage, Kirklands Hospital, Fallside Rd, Bothwell G71 8BB

Date of visit: 9 May 2018

Where we visited

Kylepark is a purpose built unit providing nine assessment and treatment beds and three low secure beds for adults with a learning disability. This visit was to both areas of the unit. At the time of our visit there were 12 patients resident in the ward, 10 of whom were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

We last visited this service on a local visit on 24 November 2016. At that visit we made recommendations around evaluation of care plans, consent to treatment documentation under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and the input from support staff to patients.

On the day of this visit, we wanted to follow up on the previous recommendations and also to ask patients how they experienced their stay in the unit.

Who we met with

We met with and/or reviewed the care and treatment of seven patients, met with two relatives and one advocacy worker.

We also spoke with the senior charge nurse, the clinical director and staff nurses.

Commission visitors

Margo Fyfe, Nursing Officer and visit co-ordinator

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Multidisciplinary input

We were pleased to see that the multidisciplinary input to the ward remains at the level noted in the last report. Patients have access to: nursing support, psychiatry, psychology, occupational therapy, speech and language therapy, dietetics, physiotherapy and the general practitioner. Pharmacy are involved on request. If the individual has been supported in the community then their community psychiatric nurses and care staff continue to attend meetings, and provide support to the individual, where appropriate, during the admission. We also noted that social work engage as required.

We were aware that the advocacy service had changed to a new organisation, North Lanarkshire Advocacy Equal Say. We understand this has meant a change in advocacy support for some patients, but were informed that the transition has gone well.

We were able to see from multidisciplinary meeting notes who attends. Individuals, and families and carers, are actively encouraged to attend meetings and have input in care decisions. Any participation is documented in the meeting notes. We also saw forward planning and discharge plans, where appropriate, as part of these notes. We were pleased to see that, in any cases that present as complex, extra multidisciplinary meetings are regularly in place to ensure all involved in the patient's care are contributing to care decisions.

Care Plans

We reviewed the care plans for all seven patients we met with. The care plans were person-centred and informative. They detailed the individuals' care needs for both mental health and physical health. It was good to see that physical health care is of a high standard.

During our last visit, we found that the care plans were regularly reviewed but the evaluation was not consistent. In some cases we found no evidence of progress or deterioration and no note of interventions used. As a result, we made a recommendation that this be reviewed and addressed.

We were pleased to see that there had been a significant change in the information within the evaluation of the care plans. We saw clear descriptions of changes in the patients' presentation, and changes to support of the patient where this was required to progress towards the care plan goal.

Use of mental health and incapacity legislation

Consent to treatment

During the previous local visit, we highlighted the need to ensure consent to treatment documentation under the AWI Act was completed correctly. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act.

On this visit, it was noted that all consent to treatment certificates relating to the AWI Act were in place and relevant to the prescribed treatment for the individuals concerned.

We noted that treatment plans attached to s47, consent to treatment forms, had been changed to remove reference to psychotropic medication for patients detained under the Mental Health Act.

Rights and restrictions

The main entry door to the ward is locked. There is a policy in place and everyone is made aware of this. There is a sign beside the door stating that it is locked. Most

patients were detained under the Mental Health Act at the time of the visit. Patients who were informal were able to ask staff to let them out. The low secure area of the ward is accessed via card swipe entry. All patients in this area are detained under the Mental Health Act. There is a courtyard area available to both parts of the unit that individuals can access. There are raised beds for gardening, seating areas and a potting shed.

We were aware that there is an emphasis in the ward on getting people outside in the hospital grounds and local community as soon as they are well enough to manage this. It was noted from care files that this is happening regularly for patients.

Activity and occupation

During the visit it was good to see staff taking patients out of the ward for activity. We noted a good rapport between the patients and staff. Activities available are varied and tailored to meet individual needs. The activities are facilitated by the nursing staff, occupational therapists and patients own support staff from the community. Participation in activities is clearly documented in the care files. One patient told us 'there's plenty on offer, if you are bored in here it is your own fault'.

During our last visit we noted that activity participation was effected by community support staff hours. We were told that both local authorities have reduced support staff hours when the individual is in hospital, even though they can still support the patient to participate in the tasks they support them with at home. We were informed that the situation had improved, but there was still a tendency to cut support hour during inpatient stays and managers should continue in their discussions with local authorities to ensure the patient's level of support continues.

The physical environment

We found the unit to be bright, well maintained and clean. Patients can access garden space directly from the ward and have access to the occupational therapy assessment kitchen for activities, as well as other areas for activities within the unit.

Good practice

The service strive to involve families/carers in care decisions as appropriate. This can be in the form of invitations to attend multidisciplinary meetings as well as meetings and telephone calls with the senior charge nurse and doctor

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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