



Mental Welfare Commission for Scotland

Report on announced visit to: Islay Centre, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 4 June 2019

Where we visited

The Islay Centre comprises of three units, with a total of 11 individualised areas that combine day/sleeping areas for the patients. In addition to this unit, Carnethy Ward provides a service for another two patients. Both units are based in the grounds of the Royal Edinburgh Hospital.

This service currently provides assessment and treatment for patients with a learning disability, who have significantly complex and challenging behaviours, often associated with a diagnosis of autistic spectrum disorder.

This was an announced visit, and we wanted to meet with patients and follow up on the previous recommendations about the review and audit of care plans, training and documentation in relation to specified persons, the development of a local policy about the service and increasing community based activities. The service had also been visited as part of the Commission's Autism Spectrum Disorder themed visit.

Who we met with

For the majority of patients in the Islay Centre and Carnethy House, their clinical presentation limits their ability to give us a clear indication of their views and opinions about their care and treatment. However, where we could, we spoke to those patients who were able to acknowledge us, and we were able to review the care and treatment of all 13 patients.

In addition to this, we met with five relatives – two of whom had support from an advocate - as well as talking to members of the multidisciplinary team (MDT). During the visit we spoke to the clinical nurse manager, the senior charge nurse, the clinical lead and responsible medical officer for the units, the occupational therapist, the speech and language therapist and various members of the nursing team based in each of the units.

Commission visitors

Claire Lamza, Nursing Officer

Dr Juliet Brock, Medical Officer

Tracey Ferguson, Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Those that we could speak to responded positively about the aspects of their care that we discussed with them. We heard about some of the activities that patients enjoyed, and those that we visited appeared comfortable and relaxed on the day of our visit. We were told that there was access to advocacy, and that for some patients, the moving on process was important for them.

We had more in-depth discussions with the relatives and MDT members that we met on the day. Relatives were positive in their feedback about the service; we heard that they were happy with the support and care that was provided. We were told that staff communicate and involve relatives in reviews of care and that they felt involved in the decisions about treatment and activities that were offered. The relatives told us staff encouraged individuals to maintain contact with them in various ways, and that they felt that this was beneficial to the patient's wellness and progress.

There were some concerns raised. We were told that, at times activities were cancelled due to staffing levels and that there were some environmental issues due to a lack of defined visiting or therapeutic spaces. We also heard that the options for moving patients on from both units has been slow to progress. For some, the provision of accommodation and care providers that can effectively meet the needs of this group of patients, has still to be established. Relatives and staff expressed their frustration regarding this issue.

Care Plans

We reviewed the care plans for all patients and found them to be well-organised and maintained. Both units use paper-based care plans, although the service is in the process of moving towards electronic records. Some members of the MDT currently use the TrakCare system when reporting their interventions, and there are certain legal documents stored electronically. This can create difficulties as it is not always immediately evident that there is a full range of multidisciplinary engagement with patient. Nursing interventions are documented on paper and allied health professional (AHP) contacts are recorded on TrakCare.

Although, following on from one of our previous recommendations, we were pleased to see that the newly developed COREPLAN provided an up-to-date overview of the activities, of all healthcare professionals involved in the patient's care. This service-specific document covers a range of areas and is evaluated every two weeks. The information in this form is helpful in understanding, at a glance, what key areas have been focused on. The sections on what went well, areas of concerns and MDT discussion were useful indicators of the how care was progressing.

We found variation in the level of detail on these forms; in some we found brief comments and incomplete sections while others were fully completed and detailed. We also found that it was difficult to track the progress that had been made over a longer period of time.

Recommendation 1:

Managers should continue to review the quality of data recorded on COREPLAN and incorporate a section that evaluates long-term actions.

Since our last visit, we were pleased to see that there has been a reduction in the number of care files for each patient. The first file that contained the COREPLAN reviews and the care rounding booklet was dynamic and reflected current activity with the patient. The second file contained assessment documents, legal paperwork and management plans associated with care goals and risk assessments for each patient. All of the files we reviewed had numerous care goals, with some patients having up to 20, yet all of these were individualised with detailed interventions that we found to be helpful in clearly outlining the steps involved in each element of care. We found thorough programmes that were used for desensitisation and for staff that were new to the unit.

However, we noted that recently updated or added goals were not indexed and it was unclear how the care goals linked with the COREPLAN, the care rounding booklet or the structured reviews that take place. We also found that some of the key documents, such as welfare guardianship orders or section 47 certificates were missing from the files, although this was discussed at the time of the visit. Further consideration should be given to the integration of the management plans in the second file with the reviews of care found in the first file, and also with the audit process of the second file.

Use of mental health and incapacity legislation

All of the patients in both units are managed under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Some patients also had welfare proxies from guardianship orders granted under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

We found paperwork relating to Mental Health Act detentions and AWI Act guardianship orders in the patients care files, other than in one file, but this was raised with staff during the visit. All forms for authorising treatment (T3) were available in the care plan and in the drug prescription sheet for the patient. The majority of forms that we reviewed were in date and covered the prescribed medication; there was an issue with one form that was out-of-date, and one issue with medication and both of these were addressed on the day.

Where there was the use of sections 281 to 286 of the Mental Health Act, with restrictions placed on individuals detained in hospital, we were pleased to see that this had been legally authorised, and that the need for specific restrictions was regularly reviewed and documented accordingly.

Rights and restrictions

We found that all patients in the unit, who had requested advocacy or legal advice, had access to these services. Although there were no advocacy staff representing patients to meet with us on the day of our visit, we found evidence of them attending reviews of patient's care.

Access to each unit is via a locked door. There is a policy in place to explain this, and patients, carers and visitors are made aware of the restriction; staff are readily available to assist anyone entering or leaving the building. Where patients were escorted on visits to the hospital's and community resources, detailed care goals for each activity was found clearly documented in each patient's file.

We also found care plans that detailed the use of seclusion, although this was described as room seclusion and prescribed seclusion. It was unclear from the care plan which type of seclusion was being used, and we found inconsistencies in the use of seclusion. We found the prescribed seclusion to be clearly documented in the medication administration chart, and the seclusion and restraint recording chart in the care rounding booklet gave a useful visual aid about the use of seclusion for the patient. However, there is a lack of clarity about the decision-making process related to the type of seclusion being used, and also on alternative strategies used to prevent this level of restriction. The Commission is currently updating its guidance on seclusion and this should be used to review local policy and procedures.

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

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

Recommendation 2:

Managers should review the definition and use of room and prescribed seclusion so that staff have a consistent approach to this restrictive practice.

Activity and occupation

We were pleased to hear that there have been developments in relation to our recommendation about access to vehicles to improve community-based activities. We were told that since our last visit, the service has been able to get access to a wider pool of vehicles, as the management and coordination of vehicles across the Royal Edinburgh site has been centralised. We found evidence of this in the patients' notes and care plans, and we could see that there were outings on a daily basis for patients in both the Islay Centre and in Carnethy Ward.

We noted that each patient has a personalised timetable involving activities, tailored to their own interests. The care rounding booklets also contained a useful section that notes any activities that have taken place in the morning, afternoon and evening, what activity was offered, how long it lasted for, the staff members involved and indicated whether the patient had accepted or refused. It was easy to see what activities and occupation patients had engaged in over a period of time.

We could see that there were outings to local amenities with staff, outings with independent sector services and staff, activities that had a social emphasis or focused on the patient's health and wellbeing. Others activities were looked at developing skills that would assist patients in moving on to alternative accommodation.

While we were pleased to see the increased levels of activity and engagement out with the hospital setting, there was less variety and frequency with activities and occupation while the patients were in their rooms. We heard that there have been developments to enhance what is offered to patients during this time, but this has not progressed to the same extent as off-ward activities.

Recommendation 3:

Managers should develop the same range of meaningful activities on-ward, as is currently available off-ward.

The physical environment

The three units in the Islay Centre, which are all accessed separately, are Harris, which can accommodate three individuals, with Rum and Barra units accommodating four patients per unit. In addition to the Islay Centre, Carnethy House provides care for a further two patients. Currently, this service, which was initially designed for 10 patients, is delivering care and treatment for 13. We were made aware of that the bed occupancy issues have remained problematic since our last visit 2017.

The impact of this is that rooms which could have been used to maintain or develop the life skills of patients in the Islay Centre do not create opportunities for this to happen. On the day of our visit, we found an activity room being used for storage and the kitchen facilities could not be used to support patients developing skills that would be useful upon discharge. For some patients, we heard about discharge plans that meant they would moving on to their own accommodation; this would provide where opportunities to be involved in a range of aspects of daily living. The current environment of the Islay centre does not presently have scope to promote these skills for patients.

Recommendation 4:

Managers should review the environmental needs of the Islay Centre so that it meets the needs of patients.

Any other comments

On the day of our visit, we heard about challenges for the service with the admission and discharge process. There are several patients who are waiting on local, community based placements to be finalised, and patients who are being admitted to the Islay Centre due to a lack of local services. We discussed this with the members of the multidisciplinary team on the day.

On reviewing the documents in the care plan, we found that the Islay Centre has developed a care rounding booklet. This useful form gave a comprehensive overview of the physical care and treatment of the patient, the daily activities provided, levels of enhanced observation and any seclusion and restraint. Completed daily, the booklet provides a review of the patient's care that presents a clear visual aide and we thought this was a good example that evaluated the patient's care.

Summary of recommendations

1. Managers should continue to review the quality of data recorded on COREPLAN and incorporate a section that evaluates long-term actions.
2. Managers should review the definition and use of room and prescribed seclusion so that staff have a consistent approach to this restrictive practice.
3. Managers should develop the same range of meaningful activities on-ward, as is currently available off-ward.
4. Managers should review the environmental needs of the Islay Centre so that it meets the needs of patients.

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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