Mental Welfare Commission for Scotland

Report on announced visit to: Blythswood House, Fulbar Lane, Renfrew, PA4 8NT

Date of visit: 11 December 2019

Where we visited

Blythswood House is a 15-bedded unit divided into three five-bedded pods, and one self-contained flat. The unit provides assessment and treatment for adults who have a diagnosis of learning disability, mental illness and behavioural difficulties. On the day of our visit there was one vacant bed which was being prepared for an admission later that day.

We last visited this service on 10 April 2018 and made recommendations about auditing patient files to ensure information was current and relevant, monitoring delayed discharges, raising staff awareness of Adults with Incapacity legislation, and recording levels of activity for patients.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and also look at progress within the service in relation to the number of delayed discharges of patients who had been in hospital for a number of years. This is because the 'Strategy for the Future' NHS GGC 2015' made a recommendation that the NHS should not be a long-term provider, and that people should be supported to live independent lives out with hospital settings where possible. This aspiration was reinforced when guidance on hospital based complex clinical care was issued in May 2015, replacing guidance on NHS continuing healthcare contained in CEL26 (2008). The MWC also published its report 'No through Road' in 2016 and more recently the Scottish Government has published the 'Coming Home' report, each highlighting the requirement to improve the lengths of time people wait to be discharged form hospital. NHS Greater Glasgow and Clyde strategic direction is in keeping with these reports and national policy for people with learning disabilities.

We were pleased to hear that since our last visit, six patients who had been in hospital for periods ranging from two years to 11 years had been discharged to a range of community placements and that there are plans for discharge for a further four patients early in 2020.

Who we met with

We met with and/or reviewed the care and treatment of seven patients and spoke with relatives by phone.

We spoke with the service manager and the senior charge nurse (SCN), and met a range of other staff during the visit.

In addition we met with the independent advocate who provides advocacy support within the unit.

Commission visitors

Yvonne Bennett, Social Work Officer

Margo Fyfe, Nursing officer

What people told us and what we found

Care, treatment, support and participation

Patients we met during the visit were satisfied that their care and treatment was good and we saw that there was a positive relationship between patients and staff on duty. Those who were able to discuss their care plans were up-to-date with what was happening in terms of discharge plans, were engaged in activities which they had identified of interest to them, and had been able to personalise their bedroom spaces to ensure a homely and comfortable environment.

Within the case records, we saw examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We felt that there could have been more consistency in the quality of the care plans. We saw what could be described as 'gold standard' examples and others which could have been expanded and developed further. We discussed this with the SCN on the day and were satisfied that the service was already aware of these inconsistencies and were working on this.

For adults whose communication was impaired, we saw detailed communication strategies with personalised communication styles and explanations of words and phrases which assisted individual patients to understand information as much as possible and convey their wishes to staff.

We noted that there was a high level of physical health care needs and that these were being addressed and followed up by a range of specialist provision supported by the learning disability service.

We heard that the service was re-focussing on the assessment and treatment input which has been diluted over the years as a result of becoming long-term care providers as a result of the lengthy delay in discharging patients into the community. As a result we would expect reviews of care plans to be robust, identifying progress and targeting nursing intervention to continue this progress. Instead we felt the reviews were more perfunctory and in the main highlighted "no change" to initial care plans. This may be a legacy from the long-term care provision the service has been delivering more recently but would recommend that the care plan reviews should be more dynamic, descriptive of progress, and the basis of informing ongoing care.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Within the records of the multidisciplinary team (MDT) meetings, there was clarity of who had attended, input from the wider allied health professional (AHP) teams and, where appropriate, families and carers and a shared understanding of the goals for each individual.

We heard from a family member about some concerns she has raised with the service. These are being dealt with through a formal process and lines of communication between parties were open.

Recommendation 1:

Managers should audit the process for reviewing care plans which reflect progress towards goals, acknowledge achievements and respond to changes.

Use of mental health and incapacity legislation

On the day of our visit, all of the patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and within patient records we saw the legal paperwork which authorised this.

We found consent to treatment documentation was up to date for both the Mental Health Act and the Adults with Incapacity (Scotland) Act 2000. In all cases and there was evidence of pharmacy input both within this system and MDT records.

There were four patients who were assessed as requiring an enhanced level of observation and we saw this being provided in an engaging and person-centred manner. We discussed the impact of this number of enhanced observation on staff capacity and were advised that this additional capacity is met through the deployment of bank staff. We heard that the pool of bank staff utilised for this purpose is made up of staff who are familiar with the unit and patients and provides a degree of consistency for patients who require this additional intervention.

Rights and restrictions

Blythswood House operates a locked door, commensurate with the level of risk identified within the patient group.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit there were four patients who were specified persons, and we saw reasoned opinion for these additional restrictions and regular view of the need for this to continue.

During our visit, we met with an independent advocate who has recently been allocated to Blythswood House. He is in the process of meeting with patients and familiarising himself with their needs to ensure that appropriate advocacy support is available as required.

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/rights-in-mind/

Activity and occupation

Since our last visit, we heard that the role of activity nurse had been terminated and that this role was deemed to be part of routine nursing role. We had commented previously that it was difficult to evidence what activities individuals had participated in and we were pleased to see that individual patients now had their own personal activity planner and that their involvement in this was evaluated as part of the MDT record.

There is a good mix of activities available within the unit, including music therapy (both one-to-one and group activity) art therapy, exercise, as well as individual activity out in the community. In addition, we saw opportunities for patients to participate in breakfast/lunch clubs and activities of daily living (ADL) sessions which were led by both nursing and occupational therapy (OT) staff. We heard that an additional OT post had been successfully recruited to and this would further increase the capacity to provide meaningful activity.

The physical environment

The unit is divided into three pods of five bedrooms with bathroom facilities en suite, and one self-contained flat which can be used to finalise preparation for discharge.

The bedrooms are large and can accommodate any equipment assessed as necessary for individual patient care. Most of the patients have personalised their bedrooms to suit their personal needs and tastes and the rooms offer pleasant and comfortable accommodation.

There are small lounge areas on each of the pods which are bright and comfortably furnished and a communal dining area for those who wish to or can tolerate eating with others.

Summary of recommendations

1. Managers should audit the process for reviewing care plans which reflect progress towards goals, acknowledge achievements and respond to changes.

Good practice

During the visit we heard that specialist learning disability inpatient services has commenced a redesign of assessment and treatment services and are working with all partners to determine the most effective service provision.

This development will also see a more formal and structured provision of outreach activity by the service which could include supporting complex discharges, providing outreach where there is a risk of admission/placement breakdown, inpatient team assessment in the community or support to community teams/carers. This is an exciting development which supports the overall vision of the service and we look forward to hearing how this progresses.

Service response to recommendations

The Commission requires a response to this 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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