Mental Welfare Commission for Scotland

Report on announced visit to: Glencairn Rehabilitation Unit, Coathill Hospital, Coatbridge, ML5 4DN.

Date of visit: 12 October 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face-to-face visits; however, this local visit was able to be carried out face-to-face.

Glencairn Rehabilitation Unit is a purpose-built unit of 12 beds for the rehabilitation and recovery of male and female patients with severe and enduring mental illness. The unit provides ongoing care and treatment whilst working towards a gradual return to the community. The unit provides a service across NHS Lanarkshire. We last visited this service on 17 September 2019, and made a recommendation around the completion of electronic record keeping; and the need for all staff disciplines to use the appropriate pages of the electronic record system to record notes from meetings, regarding patient care and treatment.

On the day of this visit we wanted to follow up on the previous recommendations and also take the opportunity to hear from patients; their views on the service, and the care and treatment and support they receive.

Who we met with

We met with and/or reviewed the care and treatment of six patients, and had telephone contact with one carer/relative.

We spoke with the senior charge nurse (SCN) and the consultant psychiatrist for the service.

Commission visitors

Mary Leroy, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with were positive about the care and support they received. Patients were able to tell us of their experiences and there was clear evidence that the patients were knowledgeable about their illness, and their rehabilitation programme. They described being actively involved in their treatment and rehabilitation, highlighting the development of life skills and also a variety of activities that were tailored to their individual needs. We noted that the service also provides information and signposted patients to access local organisations community centres local activities. Both patient and staff discussed that the pandemic had impacted on this level of engagement in the local community, but they were looking to slowly re-engage.

Patients were able to describe where they were on their rehabilitation pathway and were also able to discuss, where appropriate, their discharge plans.

For one patient where discharge from the service is delayed, we will seek an update from local authority regarding this matter.

For some patients who were awaiting new tenancies or packages of care, the service highlighted to us that some third sector agencies were having difficulties employing support staff. We note that the unit is actively addressing this issue through monitoring meetings with both local authority and service managers, and contact with the local area discharge co-ordinator.

Recommendation 1:

Managers should ensure that as well as regularly auditing delayed discharges processes, that work should continue alongside patients to expedite discharge.

When we spoke to staff it was evident that they knew patients well and delivered person-centred care. Care plans were person centred, with the involvement of the individual patient evident.

We saw that risk assessments were being completed appropriately, they appeared thorough and detailed, highlighting relevant risk areas. We were also pleased to see evidence of robust regular reviews of risk assessments.

There was also supporting evidence of patient involvement in the multidisciplinary team (MDT) meetings. Patients are facilitated and supported to attend the MDT meeting where they are encouraged to contribute and express their wishes. There was also evidence of carer and family involvement in the MDT.

The documentation of the MDT meeting is detailed and provides a good record. The clinical decisions that occur during those meetings are clearly documented and generate an action plan with outcomes and treatment goals. The MDT note was easily accessible and held on the electronic file. The meetings are attended by medical and nursing staff and other members of

the allied health care team. The MDT meetings also evidence patient involvement and attendance, some patients we met with spoke about their involvement in the decision making process.

There is a dedicated psychologist available for one session a week to the unit. We were told there that there is now funding available to employ a clinical psychologist who will provide input for both the community rehabilitation team and Glencairn (inpatient). Due to complexity of the presentation for some patients, the team acknowledged that patients would benefit from an increase in psychology input. The senior management team discussed this opportunity, how it would allow for the services to deliver a number of evidence based therapies, low intensity therapeutic group work and support for the formulation of complex care needs. We look forward to hearing about this development on our next visit to the service.

We discussed with the senior management team the lack of pharmacy input into the unit**.** We were informed that a business case has been raised due to this concern. We understand that at present pharmacy staff are responsive to requests for assistance, however they do not attend the unit regularly, or carry our medication audits on a regular basis, or are able to attend the MDT.

On the day we discussed the complex and chronic presentation of many of the patients and also for some the need for the use of high dose antipsychotic therapy. The value of pharmacy input to coordinate and complete medication regime for patients. The opportunity to discuss medication safety, identify and manage side effects and assist is the management of chronic conditions all of which will ultimately improve outcomes for patients.

Recommendation 2:

Managers to address the issue of pharmacy provision to the unit. We will write to the senior pharmacist and senior management to seek an update on the progression of this matter.

Use of mental health and incapacity legislation

Patients in Glencairn Unit were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

All Mental Health Ac paperwork was filed in a separate file for each patient. The files were easy to negotiate and it is clear from the front page what part of the legislation is in use and when renewals are required.

We found consent to treatment documentation was up to date for both the Mental Health Act and the Adults with Incapacity (Scotland) Act 2000.

Rights and restrictions

The unit is open, doors are locked in the evening for general safety and staff are available to ensure patients can enter and leave the building as they wish**.**

We had telephone contact with one relative, who was complimentary about the care and treatment being provided. They felt that communication and engagement with the clinical team was good.

We were able to see clear evidence in files of engagement with families, and of families participating in decisions about care and treatment. We felt on this visit that the ward is supporting a partnership approach to the provision of care and treatment, and that staff are encouraging relatives and carers to be as involved as they want to be in the provision of care and treatment.

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

Activity and occupation

We saw evidence of comprehensive occupational therapy (OT) functional assessments and where appropriate, reviews and discharge plans.

In each of the rooms there is a structured activity planner, all activities are led by the individual needs. All patients we spoke to reported they were happy with the range of activities on offer and there was plenty to do. Many of the patients we spoke to felt that activities offered to them were tailored to their preferences.

There are a wide range of multidisciplinary led activities taking place in the service including meal preparation and cooking groups, an emphasis of physical activity specific sports, gardening and relaxation. Prior to the Covid-19 pandemic there was a large focus on patient activity outings and sourcing appropriate external community based placements. We were told that these activities are beginning to resume as we emerge from the pandemic.

The physical environment

The unit was bright and clean and well-maintained. The unit is built over two floors. All patients have a bedroom which is en-suite. There is a games room. Sitting room and dining all are well furnished. There are two kitchens that can be used for meal preparation. There is a large garden area that is well planted with both flowers and vegetables. This space is well used during their gardening groups and many patients spoke of enjoying the garden space.

Any other comments

The Covid-19 situation has been a devastating and traumatic time; it has presented challenges that have required collaboration, commitment and finding new ways of working. We were impressed with the way in which the service has worked hard to be creative, flexible and adapt to best meet the needs of the patients and this view was echoed by both patients and staff we spoke to. It is hoped the positive changes that have benefitted some aspects of patient care can be continued and developed in future models of care.

Summary of recommendations

1. Managers should ensure that as well as regularly auditing delayed discharges processes, that work should continue alongside patients to expedite discharge.

2. Managers to address the issue of pharmacy provision to the unit. We will write to the senior pharmacist and senior management to seek an update on the progression of this matter.

Good practice

The SCN discussed with us the Standards for Inpatients mental health rehabilitation services. The AIMS approach is well–recognised, rigorous and supportive quality assurance and accreditation process for mental health services. The service is in the early stages of preparing to seek accreditation, at present they are reviewing all their systems and practice and benchmarking against respective standards. We look forward to hearing about the development of this project and its impact on improving patient care.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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: mwc.enquiries@nhs.scot
website: www.mwcscot.org.uk