Mental Welfare Commission for Scotland

Report on announced visit to:

Blythswood House, Fulbar Lane, Renfrew PA4 8NT

Date of visit: 22 September 2022

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 Routemap There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and for a time we were undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

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 were two vacant beds. One bed was for an expected admission and the other for a specific patient use converted to an activity room. The unit has a multidisciplinary team of nursing staff, psychiatrists, occupational therapy, speech and language, and psychology staff. Referrals are made to all other services as and when required.

We last visited this service on 26 November 2021 and made a recommendation regarding care plan reviews. The service response informed us that an audit programme and staff training had been put in place to ensure care plans and reviews were compiled and recorded appropriately.

On the day of this visit we wanted to follow up on the previous recommendation and also look at delayed discharges as this had been an area that has been slow to resolve and has been highlighted on previous visits.

Who we met with

We met with, and reviewed the care and treatment of eight patients, and spoke with 11 relatives, mainly via telephone.

We spoke with the service manager, the lead nurse, the senior charge nurse and the lead clinician for the service.

Commission visitors

Margo Fyfe, senior manager (practitioners) west team
Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke with were mainly happy with the care and support provided by staff. They spoke fondly of time spent with staff. The main areas of concern that were brought to our attention were about the length of time patients have been waiting in the unit for discharge and the lack of activities while staffing has been reduced. We heard from relatives who praised the care of the nursing staff but highlighted the lack of activity and the need for the environment to be more homely and inviting. We heard about the long waits some patients have had for community placements to be identified, for care staff to be employed and how this can adversely affect the patient's mental health.

We heard that visiting is once again face-to-face for all patients and is facilitated to meet the patient and their family's needs as much as possible. The staff team endeavour to ensure they have regular contact with families and recognise the struggles for both patients and their families since the relaxation of the pandemic rules. Multidisciplinary meetings are held via electronic means and face-to-face again to allow families a choice of how to attend.

Care records

As at the time of our last visit, information on patients care and treatment is still held in three ways; there is a paper file, the electronic record system EMIS, and information is also stored on the s-drive of the electronic system. We found that most information was on EMIS with copies held in the paper files. We were aware that work is ongoing to refine records management and that as this progresses, paper documentation will lessen and a more complete electronic record will be held for each patient. We look forward to seeing how this progresses at future visits.

Nursing care plans

On this occasion we found the standard of care planning had been maintained since our last visit, with clear evidence of patient involvement; again, we found the care plans to be detailed and person-centred, addressing the full range of care for mental health, physical health, and the more general health and well-being of the individual patients. It was good to see that discharge care plans were in place where appropriate. We were pleased to see a good deal of information contained in patient's one-to-one discussions with their named nurse and noted that these were happening regularly.

Physical health care needs continue to be addressed and followed up appropriately.

We saw evidence of the audit process that has been put in place to address the inconsistencies in the care plan review process. However, there are still improvements to be made. In discussion with managers, we were informed of pathways and ongoing work around this area to ensure improvement. We look forward to seeing how this progresses when we next visit.

The Commission has produced 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/node/1203

Delayed discharges

We heard about the frustrations of patients, their families and staff as a result of the length of time it takes to move patients on from the unit. We are aware that care staff shortages and the lack of community provision had made this difficult for some patients. We are aware of a new-build facility in Paisley that is in progress and that should meet the needs of some of the patients in Blythswood House. However, the completion of this service may take more than a year. We would encourage health and social care partnerships to continue in discussions with identifying appropriate placements.

We were also told about the ongoing work happening with dynamic risk registers aligned to the recommendations made in the Coming Home Implementation Report health and social care partnerships (HSPCs) that will support individuals in their community placements. This work is about ensuring that placements avoid breakdown and hospital re-admission.

Use of mental health and incapacity legislation

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) and where there was a guardianship order in place under the Adults with Incapacity (Scotland) Act 200 (AWI Act) we found the relevant documentation in place and this was accessible to staff.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. We found appropriate consent forms in place for those patients that needed them. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 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 Act. We found completed s47 certificates and treatment plans in the notes of the patients we reviewed.

Rights and restrictions

Due to the complex needs of the patients in Blythswood House, the unit operates a locked door policy and we were satisfied that this restriction was commensurate with the needs of the patients. Sections 281 to 286 of the MHA provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. As at the time of our last visit where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place.

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 heard from patients that they enjoy attending the art and music therapy groups that had been maintained throughout the pandemic. However, several of the patients we met with said that they were often bored, or that outings had been cancelled due to staff shortages, which

led to them spending a lot of time in and around their bedrooms watching television. We also heard that several patients did not have televisions in their rooms for safety reasons due to aggressive behaviours; this meant that if the patient was in their room, this activity was not available to them. Relatives also highlighted this issue and also advised us that even when outings were in place they tended to focus on food e.g. going to a fast food outlet or to local shops for snacks.

On the day of the visit, there was limited activity taking place although there appeared to be enough staff available to facilitate this. We also were unable to find evidence of activity participation in continuation notes, although it was noted in the MDT reviews that were on file. We discussed this issue with managers and it was acknowledged that activity had decreased more recently due to staffing issues across the service. We were informed of plans to restart rebound activity, which the patients enjoy and that has more of a focus on individual needs. There was agreement by the managers that it is an area of importance to the patients and needed improvement.

Recommendation 1:
Managers should ensure that patient activity is prioritised and that clear plans are in place for each patient throughout the week to participate in meaningful activity. This activity should be recorded in the daily notes.

The physical environment

The unit is divided into three pods of five bedrooms with en-suite bathroom facilities. There is one self-contained flat that can be used to support the final preparations for discharge or where a bespoke individual environment is required to best meet a patient's needs.

The bedrooms are large and can accommodate any equipment assessed as necessary for individual patient care. Most of the female patients, and a few of the male patients, have personalised their bedrooms to suit their personal needs and tastes. Each bedroom has a door to the outside of the building. However, two of the pods that are designated for male patients appeared stark and unhomely.

There were small lounge areas in each of the pods which were bright and comfortably furnished. There was a large off-pod communal dining area for those who wished to or could dine in the company of others. The dining area is also used for social activity and for visitors when they wish to use the space, with another area with comfortable seating in a bay window that is designed for visitor use. The area is nicely decorated.

During our last visit we commented that the unit was in need of re-decoration and in discussions with staff on the day of the visit, we were informed this was in hand. We noted that there had been some progress in the communal areas but were disappointed to see the lack of any change or improvement in the pod areas. We saw and were told about the privacy coverings on the windows being damaged in some areas and that made the rooms appear darker. As patients are in the unit for long periods of time, we would advise, that, as a matter of urgency, the environment be improved to benefit the patients.

There is an enclosed garden that patients can access directly from the communal areas of the unit. This has had some maintenance since our last visit, however the outside of the building is stark, surrounded with a car park.

Recommendation 2:
Service and estates managers should ensure that improvement works are carried out promptly to the benefit of the patients.

Any other comments

Staffing

We were advised that there has been some difficulty in recruiting staff however recently the service has been able to recruit seven newly qualified nurses, as well as another consultant psychiatrist. This has meant that there is now one psychiatrist per pod. To date, staff shortages have been covered by bank staff, although the unit has a cohort of regular bank staff. Managers were aware of the need to ensure there is no burnout of their regular staff team. This is an issue that has been recognised nationally and that the Commission has highlighted to Scottish Government.

Summary of recommendations

Recommendation 1:
Managers should ensure that patient activity is prioritised and that clear plans are in place for each patient throughout the week to participate in meaningful activity. This activity should be recorded in the daily notes.

Recommendation 2:
Service and estates managers should ensure that improvement works are carried out promptly to the benefit of the patients.

Good practice

Managers told us that the service has just gained Accreditation for Inpatient Mental Health Services (AIMS) around the patient journey. A significant amount of focussed work had taken place to achieve this and we commend the team and the service for their hard work.

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.

Claire Lamza
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 Commission 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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