Mental Welfare Commission for Scotland

Report on announced visit to:

Netherton Unit, 19 Blackwood Street, Glasgow G13 1AL

Date of visit: 24 November 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.

Netherton House is a seven-bedded NHS facility accommodating patients with learning disabilities and additional complex needs who require a longer period of treatment and care. At the time of the visit there were six male patients.

In 2014, NHS Greater Glasgow and Clyde published a 'Strategy for the Future' which recommended that the NHS should not be a long-term provider and that people should be supported to live independent lives, out with hospital settings, wherever possible. It was recognised at the time that this strategic direction was in-keeping with national policy for people with a diagnosis of learning disability. In Glasgow, Netherton Unit and Waterloo Close, both of whom had hospital status, were identified for a re-settlement and re-provisioning process that would ultimately result in the closure of both of these facilities.

Waterloo Close closed in August 2017 but Netherton Unit remains operational, currently accommodating six men.

We last visited this service on 3 November 2021 and made a recommendation regarding care plan reviews. The response we received from the service was that they had put an audit programme and staff training in place to ensure these were carried out and recorded appropriately.

On the day of this visit we wanted to follow up on the previous recommendation and also to review any individuals whose discharge from hospital has been delayed, as this had been an area that had been highlighted on previous visits as slow to resolve.

Who we met with

We met with and or reviewed the care and treatment of all six patients. Although relatives had been made aware of our visit none had chosen to meet with us.

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

Commission visitors

Margo Fyfe, senior manager
Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

We heard that the unit was getting back to normal following the restriction in relation to Covid-19 over the last two years. We were informed that activity out with the unit is back in place with patients being able to access clubs that they had previously attended. Visits were reinstated, and are as they were pre-pandemic; we heard that the patients are pleased to be back to doing what they enjoy.

All patients are managed under the care programme approach with notes held in paper files. All patients also have social work engagement.

Care records

We were pleased to see that care records continue to contain details of physical health checks as well as mental health care. There were detailed pen pictures of the patients in the care files. The files also held information from assessments completed by all professionals involved in each individual's care and treatment, along with comprehensive risk assessments. We found that the care records, although bulky, contained relevant and useful information for each patients care and treatment.

We found daily chronology notes on the electronic record system EMIS to be clear and concise, detailing patients' presentation throughout the day, along with their participation in activity and their interactions with peers and staff.

Multidisciplinary Team (MDT)

The unit has a multidisciplinary team on site consisting of nursing staff, psychiatrists, occupational therapy staff, psychology and speech and language therapy staff. Referrals can be made to all other services as and when required. GP input is from a local GP practice.

Urgent medical and psychiatric cover out with normal working hours is provided by the duty doctor at Vale of Leven Hospital. We heard that there had been some difficulties getting through to the duty doctor out-of-hours, with the result that this is being reviewed and the current contingency is to call the duty doctor at Claythorn ward on the Gartnavel Royal Hospital site, who will then arrange duty doctor contact with the unit.

We were pleased to see from notes, and from speaking with staff and patients, that there is a high level of involvement of the wider multidisciplinary team (MDT) in each patient's care, including dietician, speech and language therapy, occupational therapy, psychology, and pharmacy. The MDT meets weekly with discussions about individual patients taking place fortnightly. Where there is family involvement, they are included in meetings and involved as much as they, and the patients, wish in care decisions. Meeting notes detailed who attended, the discussion and the forward plan that gave a clear indication of the patient's progress. We were pleased to see that comprehensive information from pharmacy was held in the medicine prescription folders, detailing information regarding medications and high dose monitoring.

Care plans

The nursing care plan we viewed were detailed and clear. There was evidence of patient involvement, and each care plan was regularly reviewed, with accessible read versions available for use when discussing the care plans with the patients. There was clear evidence of attention to both mental and physical health care needs.

When we last visited the unit we commented that the nursing care plans were detailed and we saw evidence of patient involvement in discussing and compiling the care plans. However, we found that the reviews of the care plans held no detail in regard to how the patient had presented since the last review, nor was there any information on how the care plan was working for the patient. We discussed this with the charge nurses and recommended work be done to rectify this issue and ensure clear reviews that include patient progress to the benefit of the patients. We received an action plan from the service detailing how this issue would be addressed. On this visit we found that little had changed in the nursing care plan reviews. The standard of the nursing care plans remains good, with relevant detail and patient involvement, but the reviews still showed no detail of the patient's progress towards the care goals since the previous review.

We took time to discuss with the SCN, SN and service manager the importance of ensuring that the reviews are meaningful, person-centred and relevant to the patient's progress. We said that we would expect to see information in a review detailing interventions since the last review, information regarding what is working to assist the patient's progress towards the care goal and if there needed to be changes to the care plan that this is acknowledged.

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/node/1203

Recommendation 1:
Managers should audit the review process and documenting of care plan reviews to ensure they contain appropriate information detailing progress since last review.

Use of mental health and incapacity legislation

We viewed all patient documentation and found paperwork relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') easy to access and up-to-date. One patient had a guardianship order in place, under the Adults with Incapacity (Scotland) Act 2000 (AWI), and the paperwork was available to view. We heard that further guardianships will be applied for prior to patients moving on from the unit, and that social workers have already been engaging with all patients.

All Mental Health Act consent to treatment forms were available and up-to-date. We also found each patient had a section 47 certificate in place, under the AWI, along with appropriate treatment plans.

Where patients were having time away from the unit, pass plans were in place and easily located.

Rights and restrictions

Netherton House operates a locked door entry system commensurate with the needs of the patients. There is a locked door policy in place. The internal doors between units A and B are routinely unlocked, allowing staff and patients access to both units.

Three patients were subject to further restrictions as specified persons and these were detailed on relevant forms, along with attached reasoned opinions in patient records. These forms are needed when a detained individual has restrictions placed on them in relation to safety and security, receiving post and in the use of telephones, under the Mental Health Act.

Advocacy services were routinely involved with patients in the unit on an individual basis. Collective advocacy also attended the unit and there were ongoing discussions around how best to provide what the patients need from this service.

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 a good range of activity provision in the unit, centred on individual preferences. Patients were happy to be getting back to community activities that had been in place prior to the Covid-19 pandemic. We heard that some of the patients were once again attending a community men's group and that there is a plan in place to restart regular patient groups between the three intellectual disability units. The groups are led by allied health professionals and topics for discussion are chosen to ensured commonality for all patients attending. The patients themselves had asked for these groups to be restarted. We look forward to hearing how these have progressed when we next visit.

The physical environment

The Netherton Unit is a two-storey building that stands in its own grounds and accommodates up to seven patients in en-suite single rooms. There are four bedrooms on the ground floor and three on the upper floor. On the ground floor there is one large lounge area, a large kitchen with dining space and a laundry room that patients can use. The upper floor has two smaller lounge areas, a large kitchen diner and a laundry room for patient use along with two staff offices. It is situated in a residential area in the west of Glasgow. The upper floor is accessed by stairs only and this limits its use to patients who are fully mobile and able to negotiate the stairs.

There are shared lounge/kitchen and laundry facilities on each floor and small office spaces available.

Patients' rooms are furnished and personalised to their own preferences and offer a homely private space.

There is a small garden space with a summer house which is well maintained and patients can access.

Any other comments

Unit closure

Netherton House has been identified for closure for some time although there has been a lack of clarity about what the alternative will be for the patients going forward. During previous visits and contacts with managers we had been informed that there is a plan for the health and social care partnership (HSCP), responsible for most of the patients in the unit, to commission a bespoke service, or re-provision of the use of the current building and service from an NHS hospital service to a registered supported accommodation service. During this visit we were informed this is still the plan and that planning is progressing. The complex nature of patients' needs in the unit would suggest that detailed planning will be required to promote readiness for this significant life change for adults who rely on routine and predictability. We have asked to be kept informed of progress.

We were pleased to hear that community-based accommodation for one of the residents has now been identified, and that there is a discharge plan is in progress for him to move out of the unit early in the New Year. He was clearly happy about this move when met with him. He was particularly pleased that his family will be nearby and able to continue to visit him regularly. We heard about the detailed communication plan that had been put in place to ensure the family were involved with the discharge plan. We would like to commend the efforts of the staff in ensuring family needs were also included in this process.

Staffing

As in most areas we were told there had been issues in recruiting staff. However, we were pleased to hear that they had managed to recruit four new staff nurses and interviews for health care assistants were imminent. We heard that the unit have a regular cohort of bank staff out with their own staff group and are aware of the need to avoid staff burnout. There was a recognition of a shortage of occupational therapy time as one of the occupational therapy assistants is on placement as they are studying to be a nurse. However, interviews for an occupational therapy lead are happening. It was good to hear that the lead clinician for the service has now taken over as responsible medical officer (RMO) in the unit and now has 1.5 sessions per week which is helping with the discharge processes.

Summary of recommendations

Recommendation 1:
Managers should audit the review process and documenting of care plan reviews to ensure they contain appropriate information detailing progress since last review.

Service response to recommendations

The Commission requires a response to this recommendation within two 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 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