Mental Welfare Commission for Scotland

Report on announced visit to:

Stobhill Hospital, Skye House, Regional Adolescent Inpatient Unit, 133 Balornock Road, Glasgow, G21 3UW

Date of visit: 28 March 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Skye House adolescent in-patient unit is the specialist psychiatric unit that receives admissions of young people aged between 12 and 18 years old from the West of Scotland Health Board areas; this includes Dumfries and Galloway, Ayrshire and Arran, Lanarkshire, Greater Glasgow and Clyde (GGC) and Forth Valley. It is a 24-bedded unit, comprised of three eight-bedded wards, Harris, Lewis and Mull.

Skye House provides assessment and treatment for young people up to the age of 18 who primarily have a diagnosis of mental illness. However, on account of the continuing lack of in-patient provision for young people with a diagnosis of learning disability in Scotland and a lack of access to intensive psychiatric provision also for young people nationally, at times Skye House may be asked to care for young people whose needs are not those for whom it was primarily designed. This situation can present challenges at times.

We last visited this service on 23 March 2022 and made recommendations for a review of nursing care plans in order to improve their content and their use, to better reflect overall patient care and treatment. We recommended that any infection control testing and isolation policy should be discussed with each young person, that there should be a review of the available meal options for young people, especially in relation to the nature and range of vegetarian options, and also that when multidisciplinary team staff are required to provide duties such as mealtime management, that these are clearly documented and audited.

One of last year's recommendations reflected issues that had been brought to our attention specifically as a result of the Covid-19 pandemic lockdown and the remainder reflected more general issues that had been raised with us during our visit. We were told by the service that Skye House continues to follow NHS GGC's policies relating to Covid-19 and this year none of the young people and their families that we spoke to raised concerns regarding the implementation of the policies. Service responses to the recommendations made will be referred to in later sections of this report.

On the day of this visit, we wanted to follow up on the previous recommendations and wanted to learn about the young people's experience of staffing levels in the unit. This focus related to concerns that we had received since our last visit from a number of different sources and we are aware from contact with other in-patient wards across the country that staffing levels in mental health in-patient services have been negatively impacted by the Covid-19 pandemic.

Who we met with

We met with, and reviewed the care of ten patients, seven of whom we met in person and three of whom we reviewed the care notes of. We also met with and spoke to three groups of relatives.

We spoke with the service manager, the senior charge nurse and various members of the ward staff as part of our visit.

Commission visitors

Margo Fyfe, senior manager, west team

Dr Helen Dawson, medical officer,

Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support and participation

During our visit, we were told that the Skye House team had been keen to increase the involvement and participation of young people in their treatment and their care planning. We were told that young people and their families were regularly provided with a copy of their care plan, and that since September 2022, changes had been introduced into the service's weekly meeting schedule so that a young person's meeting alternated with the regular multidisciplinary team (MDT) meeting that meets every fortnight.

At the young person's meeting, they lead on deciding who they would like to attend, including members of their clinical team and the meeting has been designed to be smaller, supportive and orientated to respond to the views and questions of the young person. We were told that, although initial participation in the meetings by young people was somewhat hesitant, over time there has been increasing and positive uptake of the meetings by young people. The service is now considering how this approach may be extended and has considered how young people may be better included in developing their safety plans together with the clinical team.

We welcome initiatives that promote inclusion and support young people to participate and contribute to their care and were keen to hear how this work progresses. Community meetings continue to take place on a regular basis in Skye House, where questions or concerns relating to the service were raised and discussed by young people in a group setting. These meetings were supported by staff from the clinical team.

Nursing care plans

When we last visited the service in March 2022 we made a recommendation that hospital managers should review the unit's nursing care plans and take measures to improve them and ensure they reflected more closely the decisions made at the regular multidisciplinary meetings. The service told us that following this recommendation that work was undertaken to review care planning documentation that included consideration of whether the electronic case note system, EMIS, might be used differently, and also by gaining feedback from nurses and the wider MDT, regarding the care planning documentation and care planning process.

Care plans are important parts of a patient's case notes and describe the care, treatment and interventions that a patient is receiving. They form a written record of needs in which the actions and responsibilities for delivering care is outlined and detailed.

The Commission has published a good practice guide on care plans 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

The Commission has made a number of recommendations in relation to the quality of care planning at Skye House over the years. The service told us that, after reviewing the care planning options provided by EMIS, it was decided that the electronic tools available in EMIS did not provide any overall advantage. When we reviewed the case notes as part of our visit, we were disappointed that we did not find evidence of any significant improvement in care

plans during our visit. We were keen that the service prioritises this work, to ensure case notes accurately reflect the identified needs of the young people and the aspects of care provided in a detailed, transparent, cohesive and comprehensive way. We therefore repeat the recommendation relating to the need to improve care plans:

Recommendation 1:
Hospital managers should undertake a review of nursing care plans and implement changes to improve their content and their use to more accurately reflect the patient care and treatment provided overall and ensure synchronicity between the regular MDT notes and nursing care plans. To support this managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, speech and language therapy staff, physiotherapy staff, activity coordinator, specialist dietetics staff, systemic therapy and psychology staff. Referrals can be made to other services as and when required.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and to give an update on their views. We found that discharge planning was considered at an early stage in a young person's admission and that community services were able to attend the meetings, where there was liaison and communication between the family and professionals involved in a young person's care, supported by the young person's care manager.

For a number of years now ward staffing levels in Skye House have been under pressure. We have been told that the reasons behind this have changed over time, however comments and recommendations regarding these difficulties can be found in our previous reports. During lockdown, staffing once again came under particular pressure in the unit, reflecting in part, the national picture of difficulties with staff provision in mental health wards across the country. Unfortunately this occurred at a time when demand on adolescent in-patient services has been increasing, due to high levels of demand and the particular care needs of the young people referred for admission. We are pleased to learn that the management team in Skye House were taking steps to review the model of nursing provision in the unit. The review will recognise that the needs profile of the young people routinely admitted in recent years differs substantially from those of previous years; now the service requires a higher number of ward staff on a routine basis to manage the patient needs appropriately. We have been told that there are plans to increase the nursing staff complement of Skye House and, although we recognise that recruiting to nursing posts may also represent a challenge at the moment, we are keen to learn how this initiative develops and to see how increasing ward nursing staffing levels will impact positively on patient care.

Many of the young people we spoke to during our visit spoke positively of the care and support provided to them by ward staff. However, a number of young people told us of difficulties when the service has to rely heavily on agency staff to provide care. We heard how the unfamiliarity and instability of staff, and sometimes the approach of some agency staff, can

present barriers to engagement. We have been told that the management team in Skye House has tried hard to stabilise the members of staff coming to work in the unit and that some of the agency staff are now hoping to join the permanent members of the clinical team. We recognise the current pressures that are experienced by the service to try to ensure that there is appropriate nursing provision, both in terms of numbers and skill set for each ward, and acknowledge that there is no quick solution to these challenges. We also recognise that without the foundations of regular stable nursing provision in the unit, both patients and permanent members of staff will be negatively affected. Similarly, efforts and initiatives to try and improve patient care will be undermined and the ability for the service to integrate the various stands of care delivery will be much harder.

Use of mental health and incapacity legislation

On the day of our visit, 19 of the 24 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act.

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 reviewed the consent to treatment certificates (T2s) and the certificates authorising treatment (T3s) of all the patients in Skye House and found a small number of cases where treatment was prescribed but for which authority for treatment had not yet been obtained. Copies of T2s and T3s are stored electronically and for a few, we found that copies of the T2 or T3 were not printed out and available to ward nursing staff at the point of dispensation of medication. This is a helpful safeguard to ensure that the legal authority for treatment has been obtained and which we were told normally takes place. Additionally, we found a number of cases where as required intramuscular medication was authorised on the T2 form rather than receiving authorisation using the second opinion process which follows best practise.

Recommendation 2:
Hospital managers should audit practise to ensure that printed up to date copies of relevant T2 and T3 forms providing legal authority for treatment are routinely available to nursing staff at the time of dispensing of medication. Additionally audits of treatment authority should take place on a regular basis to ensure that authority for treatment is secured with particular attention paid to the authority for intramuscular as required medication, the prescribing of clozapine separately to other antipsychotics and authority for the use of melatonin.

Rights and restrictions

Locked door policy

Skye House operates a locked door policy at times both in the unit, in relation to Mull ward in particular, and towards the unit itself. Although the unit is an open unit, there are times when the level of risk of harm in the unit increases to such an extent that after an appropriate review, a decision is made by senior staff to secure both exit and entry to the unit. This practise is supported by a relevant policy and is reviewed on a regular basis (every 24 hours). Clear signage is provided to ensure informal patients are able to seek egress from nursing staff whenever appropriate during these times.

Specified persons

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are being treated on a compulsory basis in hospital in order to safeguard their welfare. During our visit when specified person restrictions were in place under the Mental Health Act we found reasoned opinions in place in the patient's case notes. However, we found that improvements could be made to ensure the safeguards were being used appropriately. We were aware that the use of specified persons regulations are, at times, difficulty, particularly in situations when some flexibility is required as to how often, and to what degree restrictions are put in place. During our visit, we found that the specified persons regulations had been used to regulate the use of mobile and internet access but that shortly afterwards, unsupervised access to the restricted items was permitted. This took place while the individual remained specified, without any corresponding plan of how specified persons was to be used. We believe that hospital managers should consider MDT training in the application and use of specified persons and review practise in the unit, especially in those cases where some flexibility in access to restricted items. Consideration should be made as to how separate care plans could be used to provide clear indications of when and how the regulations are to be used to limit personal freedoms. For those cases where there is predictable need in specific circumstances to use specified persons regulations, to access items such as the phone or the internet, then this should be clearly described in the care plan and supported with a reasoned opinion by the RMO.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Recommendation 3:
Hospital managers should consider multidisciplinary training in the application and use of specified person's regulations. Managers should also review practise within the unit and consider how practise (including the use of individual care plans) may support the use of regulations with specific details of when and how regulations may restrict an individual's access to specified items. This should correspond to documentation of the reasoned opinion in the patient's notes by the relevant RMO.

Activity and occupation

As in previous years a number of the young people and their families told us that there was often not enough to do on the ward. This was particularly the case in the evenings and weekends when organised activities were fewer and when nursing staff were having to provide additional cover for intense work required elsewhere in the unit. Some of the young people told us that they received occupational therapy involvement in their care, which the young people found enjoyable and beneficial.

Each of the three wards in the unit has its own lounge area, with access to a number of activities, including card and board games. Families are also encouraged to visit whenever possible and walks can be taken in the grounds. For many young people, school continues to provide an important structure to their day and we heard that many young people enjoy and value the range of activities school provides. We learned that for some young people, access to a wide school curriculum had been a challenge and that parents had appealed to their local educational authority; this had been successful in slightly increasing the young person's

timetable. Education provision in Skye House was provided by the hospital education service with staff employed by Glasgow City Council education department.

The physical environment

Just over a year ago, there was substantial redecoration and upgrading of fixtures and fittings in all three wards, and in the dining room of the unit. For this visit, we found the environment to be attractively decorated, with a number of noticeboards where information was provided, and encouragement given to support young people as they worked towards their treatment goals.

Young people are able to personalise their rooms and we saw a number of bedrooms with personal photos and fixtures in place. Each bedroom has an en-suite bathroom and some of the upgrading work had been undertaken in the unit that included the installation of safety features, to facilitate greater access of young people to their bathrooms throughout the course of the day. Unfortunately, one of the downsides of supporting this safer access to bathroom facilities has been that sometimes, the young people are then using bathroom space to engage in behaviours that are unhelpful to their recovery. As a consequence, when this becomes a problem, restrictions are put in place for the young person in accessing their bedroom and bathroom to limit inappropriate use. These restrictions are reviewed at each MDT meeting. None of the young people that we spoke to raised concerns about the impact or the outcome of the upgrading work on their care. A number of young people highlighted longstanding plumbing difficulties in the unit, but we heard that estates staff respond quickly to these difficulties when they arise.

The unit has a garden that some young people told us that they enjoy using, and again this year we noticed the continuing attention to detail and care given by unit staff; the unit's window boxes brightened up the reception area and entrance and helped to provide a welcoming and cared for impression for visitors and patients alike.

Last year one of the recommendations we made related to the food provided in the unit. In response to our recommendations, we learned during the course of our visit that since then, work has been ongoing with dietetics and catering services to try to better meet the needs and preferences of the young people staying in Skye House. As described last year, for any unit caring for individuals with an eating disorder, considerations about the range of food that should be available for in-patients requires careful consideration. It was good to hear from the service that since last year, preliminary work has begun to explore this issue and this has involved consultation with the young people in the unit, as well as dietetic and catering staff. During our visit we learned that food remains a problematic area for the young people both in terms of quality, the range of foods on offer, the frequency of repetition and portion size (in some cases). Many of the young people in the unit are there on a compulsory basis and do not choose to be in hospital. One of the young people told us that due to the narrow range and frequent repetition of meals on offer, they had become reliant on family members bringing food in each day to gain some enjoyment from their daily meals. We were told that work in relation to food available in the unit is ongoing and therefore we retain the recommendation:

Recommendation 4:
Hospital managers should continue their review of the available meal options for young people, eliciting the young persons, their families and staff feedback as part of that review and explore with catering managers whether there is scope to improve the meals provided, especially in relation to the nature and range of vegetarian options.

Any other comments

During our visit we heard that the Skye House management team's review of incidents in the ward over the past year has highlighted increasing problems with young people self-harming with the use of disposable vapes. Concerns about the use of disposable vapes in young people has risen more generally in the national media in recent weeks, but the particular concerns in Skye House relate to how young people there are using the disposable vapes as a means of harming themselves. Such is the level of concern regarding this activity and the risks it poses to young people that the management team at Skye House have developed a local vape policy to prohibit the use of vapes in Skye House and its grounds. This policy aims to work in partnership with young people's families to manage vapes coming into the unit and to protect the safety of the ward and the young people who are inpatients there.

Summary of recommendations

Recommendation 1:
Hospital managers should undertake a review of nursing care plans and implement changes to improve their content and their use to more accurately reflect the patient care and treatment provided overall and ensure synchronicity between the regular MDT notes and nursing care plans. To support this managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Hospital managers should audit practise to ensure that printed up to date copies of relevant T2 and T3 forms providing legal authority for treatment are routinely available to nursing staff at the time of dispensing of medication. Additionally audits of treatment authority should take place on a regular basis to ensure that authority for treatment is secured with particular attention paid to the authority for intramuscular as required medication, the prescribing of clozapine separately to other antipsychotics and authority for the use of melatonin.

Recommendation 3:
Hospital managers should consider multidisciplinary training in the application and use of specified person's regulations. Managers should also review practise within the unit and consider how practise (including the use of individual care plans) may support the use of regulations with specific details of when and how regulations may restrict an individual's access to specified items. This should correspond to documentation of the reasoned opinion in the patient's notes by the relevant RMO.

Recommendation 4:
Hospital managers should continue their review of the available meal options for young people, eliciting the young persons, their families and staff feedback as part of that review and explore with catering managers whether there is scope to improve the meals provided, especially in relation to the nature and range of vegetarian options.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk