Mental Welfare Commission for Scotland

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

Date of visit: 5 July 2023

Where we visited

Glencairn Rehabilitation Unit was 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 provided ongoing care and treatment whilst supporting individuals to work towards a gradual return to the community. The unit provides a service across NHS Lanarkshire.

We last visited this service on 12 October 2021 and made recommendations about auditing delayed discharge processes and having dedicated pharmacy input to the unit. The response we received from the service was that delayed discharges were discussed monthly at a delayed discharge meeting. Any patient whose discharge was delayed was reviewed regularly using the rehabilitation multidisciplinary team (MDT) framework. Progress has been made in trying to resolve delays that were discussed at each forum and a business case for pharmacy input to Glencairn had been put forward.

On the day of this visit, we wanted to follow up on the previous recommendations and hear how these recommendations were progressing.

We were told that funding for a pharmacist for the ward had been made available and the post advertised but there have been no applications to date. The senior pharmacist from University Hospital Wishaw is supporting the pharmacy input to the unit at this time.

There were three patients delayed on the day of our visit, two of whom are imminently moving to their own accommodation and one patient is awaiting allocation of an appropriate property.

Who we met with

We met with three of the patients and reviewed the care and treatment of eight patients. We also met with one relative.

We spoke with the service manager, the senior charge nurse, one of the consultant psychiatrists and the clinical psychologist.

Commission visitors

Anne Craig, social work officer

Mary Leroy, nursing officer

Claire Lamza, executive director (nursing)

What people told us and what we found

Care, treatment, support and participation

Care and treatment

Without exception, the patients we spoke with praised the service highly. One patient who was on pass and unable to meet with us wrote a letter and commented, "I have found the nurses, doctor, psychologists, receptionists and domestics to all be very nice, caring, considerate, kind and friendly". They also said that they "had been sick a lot and been treated well and with empathy, I don't think I would be better without nurses and doctor's care and understanding". One patient told us that they had only recently been transferred to the ward and had been initially reluctant, however, they said that in the short time they had been there the ward and the staff were "very good" and went on to articulate the positives of being transferred to Glencairn.

We met with one relative who said they were very happy with the care and treatment that their relative had received since admission, but they were worried about discharge plans. During our visit, we arranged for them to meet with the senior charge nurse to allay their concerns.

The senior charge nurse in Glencairn also had responsibility for the community rehabilitation team. It was evident that patients' transitions from Glencairn to the community was as seamless as possible across both teams as line management and the team approach was smooth, coherent and consistent.

We heard from the senior staff team that there had been initial discussions about seeking Accreditation for Inpatient Mental Health Services (AIMS) also known as Quality Networks and Accreditation, from the Royal College of Psychiatrists. This will be in conjunction with the intensive psychiatric care unit (IPCU) at University Hospital, Wishaw. These discussions were in the early stages and there was a clear will and commitment in seeking accreditation in the future. We look forward to hearing of the progress with this on our next visit.

Care plans and nursing notes

We were aware from our last visit that a new electronic recording system was being introduced, MORSE. Information on patients' care and treatment was held in three ways; the electronic record system MORSE, and two paper files, one that contained the detention paperwork for the patient and the other that held information for quick reference, such as contact details and information on the GP, CPN etc. All the information contained in the two paper files was also on MORSE, which we found this easy to use.

The care records and care plans were detailed and person-centred. Whilst these were dedicated to the rehabilitation and mental health of the patients, there was still a focus on the patients' physical conditions. For patients who had been on the ward for more than a year there was a detailed annual physical health check-up recorded in the paper notes. We saw links with the decisions that were made at the multidisciplinary team (MDT) meetings and this gave a holistic overview of the patient. There was evidence of regular and detailed reviews of the care plans. The care plans also reflected the risk assessments utilising the traffic light system model.

The ward was piloting another risk assessment framework, LSAF (Lanarkshire Safety Assessment Framework) but we felt this was not as detailed and as informative as the Traffic Light Risk Assessment documents and we expressed our view to the senior charge nurse.

We also found comprehensive information contained in patient's one-to-one discussions with their named nurse. The care plans provided a good account of the patient's journey, recovery, and discharge planning.

We were able to see evidence in files of engagement with families, and of families participating in decisions about care and treatment. The ward supported a partnership approach to the provision of care and treatment, and staff encouraged relatives and carers to be as involved as they want to be in the provision of care and treatment.

Multidisciplinary team (MDT)

During our visit, we spoke with the RMO (responsible medical officer) who had been leading on the AIMS work, although the impact of the pandemic has had a delay with this. A clinical psychologist had recently been appointed to an almost full-time post (0.85). The clinical psychologist outlined their plans to support patients by introducing frameworks such as compassion-focussed formulation and cognitive remediation. They also spoke about promoting behavioural and family therapy in the unit. Reflective practice sessions had commenced with the staff team.

Some of the patients we spoke with said that they would like more low intensity emotional conversations, strategies for coping with stress and distress, self-esteem, and anxiety management. When we discussed this with the senior team, they were already considering how they could do this. We look forward to seeing the progress made at our next visit.

Use of mental health and incapacity legislation

On the day of our visit, nine of the 11 patients in Glencairn Unit were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All Mental Health Act paperwork was available to view in a separate file for each patient. We found consent to treatment documentation was up-to-date for both the Mental Health Act as well as forms relating to the Adults with Incapacity (Scotland) Act 2000.

We noted one T2, consent to treatment form, was missing and this was immediately put in place as the RMO (responsible medical officer) was on the ward. One patient had a welfare guardianship in place. A copy of the order was not held in the patient's file and we brought this to the attention of the senior charge nurse on the day of our visit. We requested that the SCN arrange for a copy of the new welfare guardianship order be added to the file as soon as possible.

On the day of our visits, there were no patients who were under specified persons restrictions and no one was on enhanced observations.

We saw that two patients had advance statements; we also saw several patients had named person documentation on file. We asked how advance statements were promoted in the unit. We discussed with the team that this patient group would benefit from discussions about advance statements as they near the point of discharge, where they are mentally able to make

reasoned decisions. We acknowledged that it could be difficult for patients to look back at previous episodes of mental illness and think about what they would like to have done for them should their mental health deteriorate again but we advised the team that a stay in rehabilitation was an ideal opportunity to promote the use of advance statements. We will revisit this topic at future visits.

Rights and restrictions

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

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

The occupational therapist was fully involved with activities on the ward, and we heard that patients were able to work on practical skills such as cooking and budgeting in preparation for discharge. There was evidence of goal setting and individualised task identification in the care plans.

Some patients were attending gardening projects in the community and another patient had been paddle boarding with one of the staff; other patients had been cycling and golfing. It was clear to the Commission visitors that the team made every effort to increase the confidence and skills of patients to support a successful discharge.

The physical environment

The unit was bright, clean and well-maintained over the two floors. All patients had an en-suite bedroom, which was on the upper floor. There was a games room, sitting room and dining room. There were two kitchens that could be used for meal preparation.

There was a large garden area that was well planted with flowers and vegetables. This space was well used during the gardening groups, and we were told that funds had been identified to repair and maintain the raised beds, as some were beginning to show signs of wear.

Summary of recommendations

The Commission made no recommendations, therefore no response is required.

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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