



Mental Welfare Commission for Scotland

Report on announced visit to:

The Glenkirk Centre, 129 Drumchapel Road, Glasgow, G15 6PX

Date of visit: 25 January 2024

Where we visited

The Commission visits people wherever they are receiving care and treatment. Often this is in hospital, but it might be in their home, a care home, or in a local community setting. People are increasingly receiving their mental health care in the community, rather than in inpatient services, and the Commission's visiting programme has changed to ensure that we continue to hear individuals' views about their care and treatment in all settings.

The Glenkirk Centre is the base for the health professionals in the North West Glasgow Learning Disability Service (the 'NW LD service'). This is an integrated health and social care team, although the social work professionals are based elsewhere.

The NW LD service is for people aged 16 years and over who have a learning disability and live in the North West Glasgow catchment area. The catchment area has a population of approximately 220,000 people where 29% are identified as having one or more health conditions (this includes learning disability, sensory conditions, and mental ill health). There were 345 people on the NW LD service caseload at the time of our visit.

The service has an open referral system. It provides "specialist clinical assessments, recommendations and advice, specialist interventions and care planning, joint working between professionals, agencies and voluntary organisations, facilitated access to primary and secondary health care as required, and person specific training for families and carers".

The team provides care and treatment relating to "physical ill health, epilepsy, mental ill health, autism, behaviours that challenge, compromised nutrition, foot care, activities of daily living, assessment and prescription of equipment, mobility and falls, postural management, respiratory problems, swallowing issues and communication problems."

Who we met with

During our visit, we reviewed the care of 18 people. We met with seven people in person and spoke with one person by telephone. We met with the family members and/or carers of 16 individuals. We reviewed the electronic care records of nine people.

The Glenkirk Centre is mostly an office space, although has some consultation rooms. We met with a number of people in the centre. We also visited one person at home, one person in a local activity centre and seven people in a supported accommodation service in the catchment area.

We spoke with the service manager, the nurse team lead, and both consultant psychiatrists. In addition, we met with members of the multi-disciplinary team including nursing, occupational therapy, and physiotherapy staff.

On the day of our visit, concerns were raised by carers and the NW LD service manager about one person's physical health and their input from primary care services. We had already received a call to our telephone advice line about these concerns and we will continue to monitor the situation.

Commission visitors

Dr Sheena Jones, consultant psychiatrist

Mary Leroy, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support and participation

During our visit we heard overwhelmingly positive feedback about the NW LD service from the people we spoke to. People told us that the team “listened to you”. They said that team members spoke to the person and “not just” their carers. One person said that “all the staff here are brand new” and had “got (them) a wee flat”. One person said that their doctor was “great, she helped me to get off my (anti-psychotic) injection”. People and their families spoke about the team always responding to them when they made contact and that they “always called back”. Family members said that they valued the continuity of care in seeing the same people over time and that they felt supported by the service, which alleviated their worries. One family spoke about the regular contact that they had with the service and how this happened more often when their family member was unwell and needed more support. Another said that the team was “such a good service for my son” and that they had helped when there was a change in his support where the “problem was care was not right, not mental illness”. Another family said that they were “so grateful for the service at Glenkirk, I am glad they are here for my sister, they are absolutely tremendous”.

Care notes

During our visit we met with people with a wide range of health and social care needs. Each person had input from different members of the team depending on their specific needs. We saw people who only contacted the team when they needed to, for advice and support, or for people whose main contact with the service was with their psychiatrist and people who had input from several members of the team.

We reviewed health records on the electronic record system, EMIS. EMIS includes an alert to be seen when a person’s record is opened which allows professionals to highlight specific health conditions, safety issues and other relevant information. We found the alert system helpful and saw examples of it being used to alert staff about people’s legal status, physical ill health and where there were risks to others including staff.

We found that all professionals were recording their contact with people on EMIS and that in most cases individuals had contact with a range of professionals within the team. How information was recorded in EMIS varied depending on the type of contact and the professional involved. We saw a wide range of multi-disciplinary contacts and assessments relating to a variety of physical and mental health conditions.

In most cases there was a clinical entry on EMIS describing contact with a person and/ or their family and carers. An SBAR (situation, background, assessment, recommendation) format was used to record some of the contacts and this was helpful in highlighting specific actions that were to be undertaken. In one care record, we saw a highly comprehensive and detailed health needs assessment for a person with complex health needs. Where people were being reviewed through Care Programme Approach (CPA) we saw detailed and comprehensive CPA care plans which were reviewed and updated. When people had appointments with their psychiatrist, we saw copies of clinic letters sent to their GPs and relevant others which detailed the care and treatment, regular review, and subsequent changes to treatment.

Where people had an allocated nurse, there was evidence of the use of a nursing intervention plan. This tended to identify three or four different health needs and how care goals would be achieved. Whilst there was a clear person-centred focus in most of these plans, there was little detail as to the specific outcomes to be achieved or how progress towards these would be reviewed over time. In one case record we were unable to identify a clear care plan, although the family member was very positive about the outcome that had been achieved with nursing support.

There was additional evidence of care planning in the CRAFT risk assessment documentation, which allowed the team to identify specific outcomes where the person (or others) were considered to be at risk. This format was used to consider a wide range of needs and examples from the records we reviewed, included deteriorating mobility, dysphagia and swallowing problems and distress leading to agitation and the possibility of self-harm.

After reviewing the electronic care records and speaking to the senior charge nurse and members of nursing staff, we recommend that the current care plan documentation is reviewed. While we appreciate that not everyone that we reviewed was receiving active care and treatment from the nursing team, we felt that the current care plan documentation was not sufficiently detailed with regards to clear outcomes, what steps were required to achieve these, when progress would be reviewed and the outcome of those reviews.

The Commission has published good practice guidance regarding 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 review care plan documentation to ensure that it supports effective care planning with clearly defined person-centred outcomes, how these will be implemented and the monitoring and review of progress.

Multidisciplinary team (MDT)

The multi-disciplinary team consists of two consultant psychiatrists, one nurse team leader, four charge nurses, five staff nurses and three nursing assistants (one of these posts was vacant), one part time psychologist, two occupational therapists, two speech and language therapists, a physiotherapist, a physiotherapy assistant and a specialist dietician.

The team supports student nurse training and regularly has student nurses on placement within the team, in addition to students from all disciplines.

As discussed, the NW LD service is an integrated, although not co-located, health and social work team. The dedicated social work team comprises four team leaders and a number of social workers who work off site.

We heard that there has been difficulty recruiting to a number of positions in the multidisciplinary team in recent years, which has had an impact on the team's ability to undertake additional therapeutic activities. Although now well-resourced, some of the allied health professionals can be required to cover gaps elsewhere in the system, for example,

speech therapists will prioritise swallowing assessments across the wider service, but this can then impact on waiting times for speech therapy input from the NW LD service.

The team meets at the weekly multidisciplinary team meeting which all staff can attend. There are regular discussions about complex clinical situations and about people identified to be at risk of placement breakdown. Staff members spoke about how they have seen that people with increasingly complex needs were being referred to the service. In addition to the complex case discussions, the team can also raise specific concerns with colleagues via an established review system.

There was clear evidence of multidisciplinary working and a wide range of multidisciplinary care and treatment being undertaken by the team. We heard from the team that they valued joint working with colleagues and that they would be flexible in their approach to ensure that people were not having to wait for care and treatment for administrative reasons. We heard from one family that when there was a change in their allocated nurse that the process of handover was seamless and that the new nurse had a good understanding of their family member's needs.

All members of the team have undertaken basic problem behaviour support training (discussed further below). Some members of the team acted in the role of 'champions' and examples of their focus ranged from epilepsy to supporting nurse students. Other team members had undertaken specific training to provide short, focussed interventions for depression and anxiety. We spoke to team members about the use of legislation and were advised that the service medical staff provided training to the team about mental health and incapacity legislation.

A number of multidisciplinary pathways have been developed by the service with input from various members of the team. This included a transition pathway from child and adolescent to adult services, an autism diagnostic process, and dementia diagnosis and post diagnostic support. The team has good links with specialist epilepsy services and has an epilepsy link nurse.

It was evident from the electronic care records that physical health needs were regularly reviewed and considered. Whilst the annual health check for adults with learning disabilities is to be undertaken by a Glasgow-wide service, there was evidence of regular monitoring of physical health observations and ECGs (heart tracings).

Open referral system

The service has an open referral system which means that they will accept a referral from anyone. In addition to letters of referral and referrals via an electronic system, the NW LD service also runs a telephone referral system during working hours. This is staffed by the nursing team and allied health professionals on a rota system. The person who takes the call will undertake an initial review and consider what, if any, actions are required at that time. They can allocate the person to the most appropriate member of the health and social work staff. The referral will then be discussed at the multidisciplinary team meeting and further consideration is given at that point regarding the need to involve other members of the team.

We heard from individuals, families and carers that we spoke with that the NW LD service always responds to contacts and that this is valued.

We also heard that the NW LD Service had links with community organisations including supported accommodation services. One of the supported accommodation services we visited has a regular fortnightly visit by one of the learning disability nurses and we were told by family members how valuable this is. Another family member commented that having an identified point of contact supported direct communication with the NW LD service.

One concern we heard from the team was with regards to funding for people's care packages. We heard from staff that it can be difficult to get people the increased funding that they need, particularly in a crisis. There can also be occasions where funding is agreed but there is no support organisation who is able to provide the service that is needed at that time.

Use of mental health and incapacity legislation

Where people were receiving their care and treatment under the Mental Health (Care and Treatment)(Scotland) Act 2003 (the Mental Health Act) we found that the relevant documents relating to the Mental Health Act were easily found in the electronic care records.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given, to individuals who are receiving their care and treatment under the Mental Health Act. Certificates authorising treatment (T3) were in place, where required, and corresponded to the medication being given.

In some cases, the EMIS alert system, referred to above, included information about the person's legal status and specifically whether they were receiving care and treatment under the Mental Health Act; this was helpful.

Where people were receiving care and treatment under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) we saw that there was a lack of consistency in how the use of the AWI Act was recorded. In some cases, reference to the AWI Act was referred to on the alert system, and the relevant certificates were kept in the care record, however in most of the care records that we reviewed there was no information about the AWI Act on the alert and no certificates available in the electronic records.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We did not have sight of any section 47 certificates and their associated treatment plans in the case records we reviewed.

We did see evidence of good communication with welfare proxies, where people were receiving their care and treatment under the AWI Act, however two family members that we spoke to advised us that they held power of attorney for their relative and we saw no record or documentation regarding this when we reviewed the care records. In addition, one person, who holds power of attorney for their relative, told us that they had not been included in any

correspondence about their relative's care and treatment. This had already been raised with the service before the day of our visit and addressed.

Recommendation 2 :

Managers should ensure that copies of all legal certification, including section 47 certificates, power of attorney and welfare guardianship certificates are kept in the persons' electronic care record on EMIS.

Rights and restrictions

When we met with people who had received treatment under the Mental Health Act, it was clear that they had had support to understand their rights, access advocacy and seek legal advice.

When we reviewed the available records, we looked for evidence of advance statements. These are written statements made under sections 274 and 276 of the Mental Health Act and are written when a person has capacity to make decisions on what future treatments they may or may not want. Health Boards have a responsibility for promoting advance statements. We found reference to an Advance Statement in one care record and that document was stored in the legislation section of that record.

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.mwscot.org.uk/law-and-rights/rights-mind>

Activity and occupation

We were pleased to hear about the therapeutic interventions and groups provided by the NW Learning Disability team. We also heard about these activities from people and their families and saw evidence of them in the electronic care records.

As discussed above, the group activities that the team had provided in the past were impacted by the pandemic and staff shortages. With improved recruitment, it is intended that these activities will recommence and we look forward to seeing progress with this.

One family told us about the psychological therapy that their relative received after they developed a psychotic illness. They told us that their relative created a 'coping' book that helped them when they were distressed by auditory hallucinations (when they heard voices as part of their psychotic illness). That person also attended a week-long psycho-education programme run in a community organisation and told us how much they enjoyed this.

Another family talked about the support, education, and advice that they received when their relative was diagnosed with dementia and how this helped them to understand what would happen.

Other activities and interventions provided by the service included relationship and sexual health (provided by health and social work colleagues), health and weight, and programmes for depression ('Beat it' and 'Step up').

Positive Behaviour Support

As noted above, all the team were trained in basic Positive Behaviour Support (PBS). PBS includes a range of pro-active strategies which aim to improve quality of life by better understanding the meaning of each person's behaviour. In addition, a nurse and a social worker in the team have undergone further specialist training and achieved a Postgraduate Certificate in PBS. Either can accept referrals for behaviours that challenge, depending on the specific circumstances of each individual.

Physical health

Greater Glasgow & Clyde Health Board have taken a service wide approach to the implementation of the annual health check for adults with learning disability by creating a specialist team to provide this service.

Throughout the care records that we reviewed, we saw that physical health was regularly considered and that all the multidisciplinary team were involved in meeting physical health needs resulting from a range of conditions – including mental ill health, dementia, epilepsy, and pain.

In the past, most people receiving psychotropic medication would have had physical health monitoring in relation to that medication undertaken by their GP. As some GPs no longer provide physical health monitoring where it relates to mental health, the team has expanded their role to ensure that any such needs are met in their own service, and are looking to establish physical health monitoring systems.

Where people are receiving Clozapine medication, they can attend the Clozapine Clinic offered in general psychiatry services, and this system works well.

The physical environment

The Glenkirk Centre is the base for the health professionals and administration staff. Social workers in the team are located elsewhere. People attend the Centre for some of their meetings with the team, but most of the team's activity happened in the community.

Any other comments

Throughout the visit we met with enthusiastic staff members who were committed to providing good care and treatment, working with other professionals in their team and who interacted with respect, positivity and care with individuals, families, and carers.

Summary of recommendations

Recommendation 1:

Managers should review care plan documentation to ensure that it supports effective care planning with clearly defined person-centred outcomes, how these will be implemented and the monitoring and review of progress.

Recommendation 2 :

Managers should ensure that copies of all legal certification, including section 47 certificates, power of attorney and welfare guardianship certificates are kept in the persons' electronic care record on EMIS.

Good practice

The open referral system and telephone referral line are valuable in ensuring a timely response and in reducing the barriers to care that people with learning disability often experience.

We also saw that when appointment letters were sent out to people that they used an accessible format using plain english, pictures and symbols. The speech therapists also ensured that letters relating to our visit to the Glenkirk Centre were in an accessible format and we are grateful for their support.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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