Mental Welfare Commission for Scotland

Report on announced visit to:

Kylepark Cottage, Kirklands Hospital, Fallside Road, Bothwell G71 8BB

Date of visit: 11 May 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.

Kylepark Cottage is a purpose built inpatient service providing nine assessment and treatment beds and three low secure beds for adults with a learning disability. The ward is mixed-sex. All rooms are single with en-suite facilities. The unit was not full at the time of our visit, three beds had been closed due to staffing levels. There were seven patients on the ward. We last visited this service on 3 June 2021 and made recommendation on ensuring that patients' participation is evidenced on care plans, reviews and meeting notes. The response we received from the service was that all named nurses had been signposted to the Commission's good practice guide on person centred care plans and have been reminded of the importance of detailing the involvement of the patients in care planning. We planned to review care plans to ensure that recommendations were being met.

On the day of this visit we wanted to follow up on the previous recommendation and also to hear how patients and staff have managed throughout the recent pandemic.

Who we met with

We met with, and reviewed the care of five patients, two who we met with in person and three who we reviewed the care notes of. We did not meet with any relatives and no relatives had asked for contact.

We spoke with the senior nurse, the senior charge nurse and the clinical psychologist.

We also met with mental health officers/welfare guardians and social workers attached to three of the patients on the ward.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

When we last visited the service we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We made a recommendation that there should be clear evidence of the patient involvement in the care plans and reviews. On this occasion we found person-centred care plans that were very detailed, specific, clear and evidenced patient involvement. We were pleased to find easy read versions of the care plans which were used in patient discussions. Care plans were also regularly reviewed. It was good to see that discharge care plans were in place where appropriate. We also found a good deal of information contained in patient's one to one discussions with their named nurse. Risk assessments were also person centred and current.

We saw that physical health care needs were being addressed and followed up appropriately and timely.

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 and psychology staff. Referrals can be made to all other services as and when required. It was clear from the very detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and update on their views. There was reference to the previous MDT meeting goals, outcomes and named persons responsible for actions. The meetings also included the patient and their families should they wish to attend. It was clear to see from these notes that when the patient is moving towards discharge that community services also attend the meetings. We were told by mental health officers and social workers that there are strong links with the team at Kylepark Cottage and this has been crucial in supporting transition from in-patient to independent community living.

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. Meetings will continue to be held in this way as it allows for ready access to professional consultations and decision making. Families and carers are invited to all meetings and if they do not attend they receive minutes of the meeting or if preferred they receive telephone updates.

Discussion with the senior nurse and the senior charge nurse highlighted concerns in retention and recruitment of qualified nursing staff to support the acuity of the patients but also to provide a full service where patients could be appropriately placed in a specialist unit to meet their needs, rather than being cared for in an adult mental health admissions ward. At a senior management level, creative and innovative solutions to workforce planning are in progress, including an open evening, exit interviews to inform why staff are leaving the service and offering a new model of working supporting work/life balance. Contact has been made with universities to encourage staff nearing the end of their training to consider working in learning disability in-patient services and the universities have been responsive to supporting this. Patients did comment on the difference in the care they received when bank or agency staff

were on the ward. This is a direct consequence of being unable to recruit to the permanent staff team.

We spoke with the clinical psychologist for the ward who advised that providing a consistent service to the ward was difficult at times due to the current post holder securing a promoted post late last year. The allocation for psychology is 0.5 wte time post, equating to 2.5 days per week. However, a clinical psychologist has been recruited for the ward and will take up post in early June. There is also an assistant psychologist who provides support to the patients on the ward.

Input to staff and training about positive behaviour support (PBS) and its implementation has been a challenge due to the staffing issues. All permanent staff have completed a Learnpro online module in PBS. The ward manager and psychology service are working together to provide further training including discussions about how to ensure permanent staff have access to up to date training e.g. video-based training that can be accessed in a more informal way.

We discussed the considerations of ongoing psychology support when a patient returns to the community and whilst there is a pathway in psychological services for this transition there can be challenges due to staffing issues in psychological services. The current staff shortages can often lead to the ward psychologist keeping cases open for longer than the agreed time (six weeks post discharge).

There is ready access to advocacy services for the patients, many of who already have an advocate in place.

Care records

Information on patients care and treatment is held as a paper file. There is no electronic recording system at Kylepark Cottage. We found this easy to navigate. Nursing notes are of a high standard, are meaningful, with appropriate non-judgemental language being used throughout.

Use of mental health and incapacity legislation

On the day of our visit, seven of the seven 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.

All documentation pertaining to the MHA and AWI including certificates around capacity to consent to treatment were in place in the paper files and were up to date.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place however we noted that PRN medication had not been recorded appropriately on two T3's and we discussed this with the senior charge nursing during our visit who advised she had raised with the consultant psychiatrist who dealt with this quickly.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

If there was a welfare guardianship under the Adults with Incapacity (Scotland) Act 200 (AWI) patients knew what this meant for them. Copies of welfare guardianship orders were on file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. All s47 certificates were on file and completed appropriately.

Recommendation 1:
Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.

Rights and restrictions

Kylepark Cottage continues to operate a locked door, commensurate with the level of risk identified within the patient group.

Where specified person restrictions were in place under the MHA we found reasoned opinions in place. 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.

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

When we are reviewing patient files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not see any advance statements on file, but we were informed that staff will support the patients to complete them, particularly as they move toward discharge.

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 are aware that during the pandemic restrictions put in place had meant that various activities out with the unit had to be paused. However, we heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients. Pet therapy was in progress on the day of our visit. We were told that the staff actively encourage patients to

enjoy national celebrations, such as the recent King's Coronation, Easter, St Patrick's Day and many others. We heard that there are dominoes and card games and staff accompany patients on outings to the shops when they can. One patient highlighted the importance of spending time with the occupational therapist, they felt this has been particularly useful in learning new life skills in preparation for living independently in the community.

There is ready access to outside space and where possible patients are encouraged to take advantage of this. One patient mentioned they were very keen on the gardening group and we saw some photographs of their efforts.

We heard that staff have gone the extra mile to facilitate activity and ensure patients' needs in this area are met.

The physical environment

The ward is bright and welcoming. There is a sense of space and light, but can also provide privacy if that is required. The ward has four corridors with three bedrooms in each that lead from a central area nurses station. Each area has a themed colour to orientate the patients to their wing of the ward. This colour coding follows through to the garden area. We consider that it is important for patients to have access to outdoor safe space.

There was significant efforts deployed to soften the ward with murals on the walls, decorative artificial trees and flowers strategically placed throughout.

Any other comments

Throughout the visit we saw kind and caring interactions between staff and patients. Staff spoken with knew the patient group well. It was good to note that patients met with highly praised the staff, one patient commented "the staff here respect me" and they "get on well with staff, sometimes they bring up the good times when am having a bad day". Another patient told us that they were "happy with the nursing staff, they had no complaints".

There were three patients on the ward whose discharge was delayed. This is a direct consequence of requiring appropriate accommodation and securing care provision for discharge. One patient requires purpose built housing which is in the early stages of design and build. We heard from the social worker and mental health officer for this patient how much they appreciated the care and attention staff provided for them but also about the multi-disciplinary working and planning that has gone into the arrangements for the purpose built home.

The health and social care partnerships for these patients are actively trying to secure accommodation and service provision to enable a safe and sustainable discharge from the ward to the community. We will continue to monitor the progress of these patients.

Summary of recommendations

Recommendation 1:
Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.

Service response to recommendations

The Commission requires a response to this recommendation 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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