Mental Welfare Commission for Scotland

Report on announced visit to: Blythswood House, Fulbar Lane, Renfrew PA4 8NT

Date of visit: 08 May 2024

Where we visited

Blythswood House is a 16-bedded unit that provides assessment and treatment for adults with learning disability who are presenting with mental illness and/or behavioural difficulties.

The service is divided in to three separate five-bedded pods and one self-contained flat. On the day of our visit, there were 15 people in the service and one vacant room.

We last visited this service in September 2022 and made two recommendations. The first was that patients had access to meaningful activity, set out in care plans and recorded in daily records. We heard from the multi- disciplinary team (MDT) that a significant amount of work had been undertaken. A programme of activities had been created, with activities seven days a week, including individual and group activities; this had been established in the last two years and has contributed to a 23% reduction in incidents in the ward, and a 46% reduction in the use of restraint.

The second recommendation was to ensure that improvement works were carried out promptly when required in the unit. We heard that redecoration was an ongoing process in the service, including ensuring that peoples' bedrooms are decorated and personalised, as they would like. We were told that there is prompt reporting of anything that is needing fixed, and that maintenance are in the unit on most days undertaking repairs. A number of more significant maintenance projects are pending, including a safe zone and a bedroom that has damp. We heard from the senior charge nurse that some planning is required around these bigger pieces of work due to the disruption and distress they can cause to people living in the service. In the case of the damp bedroom, it is necessary for that person to be out of the unit for a week to allow the work to be done, and a plan had been made for them to spend time with family and carers.

On the day of this visit, we wanted to follow up on the previous recommendations and look at the care and treatment of people identified as being a 'delayed discharge'. This refers to someone who is considered ready to leave hospital but where this is delayed for any reason, as this has been highlighted as a concern on previous visits. At the time of our visit, all 15 people in Blythswood House were considered ready for discharge. Six of those people were due to be discharged from hospital in the next three months and a further two people have since had a provisional date for discharge set for the end of June 2024; this had been delayed from an initial date of April 2024. Four people have no discharge plans at this time, and we will continue to monitor progress in these cases.

Who we met with

We met with five people in person and reviewed the care notes of 10 people in total. Prior to the visit, we had had telephone contact from three carers/family members, two of whom also met with us on the day of the visit.

We spoke with the service manager, the senior charge nurse (SCN), and all three consultant psychiatrists before and during the visit. We also met with three registered nurses and one health care assistant.

On the day of our visit, we had a tour of the service that included the three main pods, the outdoor and communal activity, dining, and occupational areas. We spoke with a number of people who were enjoying an art group and saw one person who was slowly being introduced to the large rebound trampoline in the dining area. We could see that people were making use of all the areas of the unit as well as going out into the community to participate in activities.

Commission visitors

Matthew Beattie, higher trainee, general adult psychiatry

Andrew Jarvie, engagement and participation officer

Sheena Jones, consultant psychiatrist

Gemma MacGuire, social work officer

What people told us and what we found

One family member told us that the care that their daughter had received was “absolutely fabulous” and had completely turned things around for her. Since admission to Blythswood House, their daughter was no longer presenting with symptoms of mental illness and suitable supported accommodation had been found for her in the local area where she had lived for many years.

Another family member told us that their relative is in “good hands” in Blythswood House and considered the team to be their “lovely NHS family”. At the same time, they spoke of their concerns that at times, there had been poor communication from the service and that they were still waiting for written information that had previously been provided verbally.

One person that we spoke to was distressed about a recent incident with a peer and spoke about two episodes of restraint. We could not immediately find the record of these incidents but were able to review them later in the day. We had a discussion with the SCN about de-briefing for people after significant incidents. We heard when there have been incidents, support for individuals happens informally. We also heard that some people could find it difficult to talk about incidents at a later time when things have settled down. Previously, talking mats (an assisted communication technique) had been tried, but was not found to be helpful. The SCN told us that a short-life working group is currently reviewing and updating the de-brief and reflective practice processes with the lead speech and language therapist (SLT) leading on the de-brief process for patients.

We spoke to a manager at a local school who had supported one young person during their education in their contact with adult mental health. They said that they were “so impressed by the care and treatment” the young person had received in Blythswood House. They said that they had had little hope for the young person when they were first admitted to psychiatric services, but that on the day that they were admitted to Blythswood House they thought, “it is going to be okay now”. They could see that the team spent time getting to know the individual and listened to them. The manager told me that they knew when to engage with the individual and when to give them space. The manager also said how disappointing it was that the individual needed to go in to an ”institutional” setting as they were not mentally ill, and it had been evident for a long time that they required a specialist, supportive environment in which to live, but none was available.

A parent of one person who had been recently admitted to the unit said that when their family member was first admitted, the doctor took a full life history from them, which had never happened before. They went on to say that, they were happy and reassured by the discharge planning process, which included contingency planning and linking with care staff after discharge.

Blythswood House operates a waiting list and prioritises people from that waiting list who require specialist inpatient care and treatment due to mental ill health and behavioural difficulties. At the time of our visit, there was one person in the community who awaited admission for specialist assessment and treatment relating to behaviours that challenge. There were also four people with learning disability in general psychiatry services who were not felt to require admission to Blythswood House; they are awaiting appropriate supported

accommodation. We were told that a review of local data had shown that people tended to be discharged more quickly from mental health than learning disability settings, with discharge from mental health settings tending to occur within 12 months of admission.

Care, treatment, support and participation

Care records

As at the time of our last visit, information on patients care and treatment is still held in three ways. There is a paper file, the electronic record system EMIS, and information is also stored on the s-drive of the electronic system. We were told that work is ongoing with regards to how progress can be made to the use of EMIS alone, and that working across three systems could cause problems.

We reviewed records for 10 people across these three systems. We were impressed at the range and detail in the information that we looked at.

In the paper files, we found a wide range of documents and care plans relating to each person's background and admission information, some of which was recorded in 'About Me' documents.

There were detailed nursing care plans, covering a range of mental and physical health and behaviour. The person-centred focus was evident, with a range of information including activities, physical health, diet, and managing distress.

There were a range of risk assessment and management plans; these were also detailed. 'Positive behaviour support plans' contained comprehensive and meaningful information about how to support people when they were becoming distressed, and when they placed themselves or others at risk; this included the use of traffic light systems. There were individualised care plans for people, detailing how to support them depending on how they are feeling at any given time, and particularly if they are becoming distressed or agitated.

We also saw information about peoples' sensory needs, communication information, and a range of communication tools in peoples' records and throughout the unit. We saw a number of rating scales in use in the service that allowed the team to monitor peoples' progress and their response to treatment.

It was evident that peoples' physical health needs were well understood and managed.

When we reviewed electronic records on the EMIS system. We noted that there was a helpful pop-up box that was used to alert staff to key issues relating to the individual. This might be information about the person's legal status under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), information about the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) and whether the person had a welfare guardian, important physical health information, and any risks specific to that person.

In EMIS, we could see that there were daily recordings of one-to-one activities and time spent with people, relating to physical health and recording of the person's activities that day.

The care plans that we read in peoples' files covered a broad range of needs, were trauma informed and person-centred. For one person, who had experienced significant trauma since childhood, there were a number of visual tools to support and prevent distress for that person.

We were told by the SCN that there was new documentation being used to record the weekly MDT meetings and these were easy to find, included detailed information and allowed actions to be allocated to staff each week to ensure progress. We heard that there was discussion with people and carers/families before and after the MDTs, to ensure that there was good communication between all. In addition to these meetings, there were regular review meetings and Care Programme Approach (CPA) meetings, which are structured multidisciplinary health and social care planning meetings, and carers and families generally attended these.

Two people had anticipatory care plans about resuscitation in the event of a significant medical event. These were appropriately completed, dated, and recorded the involvement with the relevant welfare guardians.

Multidisciplinary team (MDT)

The multidisciplinary team at Blythswood House includes registered nurses, healthcare assistants, charge nurses, and a SCN. A psychologist is based in the service part time; there is a band 5 occupational therapist and occupational therapy lead, who are also based in the service. There are three consultant psychiatrists who have responsibility for one pod each, SLT, and a weekly in-house physiotherapist as well as access to dietetics when needed. There is a twice-weekly visiting GP service and cover for medical issues in between times.

We spoke with a number of staff members and heard from all that the change in working practices in the service were positive. We heard that the change to working as one whole service as opposed to small teams in the pods meant that there was less duplication of work and that there were less mistakes with medication. We heard that the nursing staff could work with any of the people in the service as they knew everyone. We heard that the daily safety huddle that had been introduced was positive in ensuring that people had the right staff member working with them on any particular day, depending on how they were feeling and if they were distressed.

All the staff that we spoke with indicated that the SCN had played a significant role in the positive changes in the service.

We spoke with three registered nurses, and they all told us that the supervision, reflective practice, and the leadership model was positive. One registered nurse spoke about the hard work that had gone in to progressing discharge options for people, particularly after the limitations linked to the Covid-19 pandemic.

We heard from one member of staff that there could be difficulties when there were bank staff working in the service, who were less familiar with people and who may not be so motivated. We asked the SCN about this, and were told that wherever possible, bank staff are used who are familiar with the service and have worked there before. During the daily huddle, the staffing needs of both Blythswood House and another service in Glasgow are considered, and staff can move between the services depending on where the greatest need is at any time. Agency staff who are not familiar with the service are not used.

We also heard that health care assistants now also attend the MDT meetings, to ensure that their knowledge of people is shared in the meeting, and it was acknowledged how valuable this is.

We heard from some members of the team about the positive behaviour support (PBS) knowledge and experience in the team. Blythswood House has one part time consultant psychologist and one assistant clinical psychologist who provides input to the ward and does a lot of work around supporting people with behaviours that challenge. There are also a number of nursing staff who have completed their postgraduate course in PBS, and their knowledge supports people and other members of the team in using this approach.

We were told that the links with social work teams are generally good. Most people admitted to Blythswood House have an allocated social worker prior to admission. There are also good links with the various social work teams via other service processes.

A new leadership team has been established, with a focus on staff development and staff retention. There is a practice leadership model using positive role modelling and regular team meetings. There are daily 'safety huddles' at the start of each day to review any incidents or concerns and consider staffing levels (including skill mix and staff gender where relevant to an individual's care and treatment needs). This has supported staff to feel safer and ensure that staffing levels prioritise peoples' activities as set out in their care plans.

The MDT weekly meeting has a standard meeting template that records the discussion at the meeting each week, and includes detailed action points allocated across staff team, which are reviewed weekly.

Delayed discharges

At the time of our visit, eight people were progressing to discharge in the next few months. We were aware of a number of recent discharges of people who were 'delayed' in hospital.

When people are in the transition to discharge process, there are weekly 'core group' meetings involving health and social care teams, carers and families and community support organisations, to ensure communication between all involved and progress towards discharge.

When people are discharged from Blythswood House, they can be supported by a wide range of community support providers, some of whom have not worked with the Blythswood team before. The SCN told us that they have set up orientation meetings for the senior staff in these community organisations so that they can establish good links with the team; there is now a good understanding of the transition and discharge processes and the sharing of information with the support workers in their organisation. This has been helpful given the number of new people that can support people in the service.

A number of individuals have no clear discharge plan. In some cases, there is no accommodation identified and for others there is no community support organisation identified. Where individuals require bespoke service delivery, alternative commissioning models are being considered.

One person is considered to require nursing care in addition to specialist mental health and learning disability care and treatment. However, no care home has been identified that can meet their complex needs. How their needs can be met through commissioning of a bespoke service is being considered.

There are regular meetings involving senior health and social care managers in line with the Coming Home Implementation Report and Dynamic Support Register meetings. This ensures strong links between health and social care teams and can lead to good collaboration where people are identified as at risk of placement breakdown, or where they are delayed in hospital. There is a multi-agency collaborative group linked to the Coming Home work, which has input from service providers, advocacy services and Scottish Consortium Learning Disability. This provides a forum for discussion and alternative approaches when no discharge options have been identified for people.

Use of mental health and incapacity legislation

On the day of the visit, 15 people were detained under the Mental Health Act. All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were easily accessible and correct.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 where required and corresponded to the medication being prescribed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act, and 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. 14 people had an up-to-date section 47 certificate, and associated treatment plan. One person was able to consent to their medical treatment.

The majority of people were also subject to welfare guardianship. The appropriate documentation regarding this was present in people's files.

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. Two family members spoke to us about not being able to act as their family members named person under the Mental Health Act, as their relative did not have the capacity to nominate them. In one case, this had been resolved as the relative was now their welfare guardian. In the second case, the family were in the process of seeking welfare guardianship but had also been supported by the social worker who was a mental health officer, to access relevant paperwork.

Rights and restrictions

The service operates a locked door policy at the main entrance. In the service, it was evident that there had been a change in practice with the entrance doors to the pods that were now no longer being locked. This has allowed people to access all the areas of the service, and we

could see at the time of our visit that people were moving around freely, between the pods, the activity areas and in the main corridor. Some people also preferred to keep the door open from their bedroom into the courtyard area, although this was not available for every bedroom.

People had access to advocacy services, particularly in relation to Mental Health Act processes. We were aware of advocacy acting on behalf of people in Blythswood House. One person told us that they had been offered an advocate in the past, but they were not clear what this really meant. We discussed the role of advocacy with them, and they did not want to pursue this further.

Sections 281 to 286 of the Mental Health Act 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. We found that specified person restrictions were in place under the Mental Health Act for three people. In each case, the appropriate paperwork was present and correct.

Since our last visit, there has been one significant incident in the service. We understand that the internal review of this incident is nearing completion. We were told that the draft report highlighted the need for staff training and development and these recommendations have already been actioned with an updated staff debrief process and reflective practice approach. We look forward to seeing the final report in due course.

Activity and occupation

Lack of activity and occupation was highlighted at the time of our previous visit and a recommendation was made to ensure that people had access to meaningful activity, as set out in care plans and recorded in peoples' care notes.

We heard that a significant amount of work had happened in relation to meaningful activities for people, both individually, and in groups led by the occupational therapy team, which has contributed to a reduction in the number of incidents occurring in the ward and in the use of restraint.

There is a programme of in-house activities provided seven days a week, with a morning and afternoon activity each day. These include a new music group which has good engagement, a 'grow and learn' gardening group that encouraged people to spend time outdoors, a weekly bingo session, and a Stop-Go animation group that was also well attended.

On the day of our visit, we saw people taking part in an art activity in the activity room. There were people going out to the community to engage in community-based activities and people walking around the outside of the building and off visiting the local park as part of the walking group. We heard that the walking group had supplied everyone (including staff) with pedometers and that they had a shared goal of walking enough steps to collectively 'climb' Ben Nevis.

In addition to the group activities, each person has an individual programme of activities in the community that included attending community art and cooking groups, going out for walks, visits to parks and undertaking shopping.

A number of other therapeutic activities take place regularly in the service. There is a weekly art therapy group with a sensory focus, and a relaxation activity every week. Blythswood House also has a sensory room that people can use. There was also access to other service-wide activities via a psychology-led wellbeing programme launched, with access to activities such as yoga and qigong, a meditative movement technique.

Service user meetings had been established and there were monthly themed meetings. Themes have included activities, safety planning, and the Coming Home report. There are smaller meetings in the pods that take place in between the monthly meetings; these give everyone the opportunity to attend, as not everyone wants to attend the monthly meetings. Group sessions have been provided via the service user meeting programme and these have included anger management and relaxation.

We also heard that there has been a working group established to consider the lifestyle and health of people admitted to Blythswood House, with a focus on healthy eating and increasing activity levels. The intention is that each person will have an individualised lifestyle assessment leading to an action plan that will ensure a broader focus on each person's health and well-being.

The physical environment

During a previous visit, we were aware that the vacant room had been used as a bespoke activity area for a person who was unable to use communal areas due to their mental health. We were pleased to hear that they had made significant progress and are now able to access shared areas of the service. The vacant room is to be adapted to provide a ligature free bedroom or 'safe zone' for people who are at risk of self-harm.

Following our last visit, we recommended that the environment be improved due to concerns about two bedrooms that were stark and unhomely, as well as the need for redecoration in the pod areas and damaged window privacy coverings.

Prior to this visit, we were told that all repairs were being promptly reported, that there was a review of the environment regularly throughout the day, that there was an ongoing programme of redecoration and that people were supported to personalise their bedroom areas.

We visited each of the three pods on the day of our visit. We did not visit the self-contained flat, as this would have caused distress to the person who is living there.

The bedrooms are large and can accommodate any equipment assessed as necessary for individual patient care. Each bedroom has a door to the outside of the building, be that into the courtyard or to the rear garden area. There were small lounge areas in each of the pods.

There was a large, central dining area where people were encouraged to eat. People can also eat in smaller groups, in areas such as the occupational therapy kitchen as they choose. The dining area is also used for social activity and for visitors when they wish to use the space, with another area with comfortable seating in a bay window that is designed for visitor use. This room was clean and bright with lots of windows, and some decorations had been put up in the area.

The dining area also contains the large 'rebound therapy' trampoline – the only area where this equipment can fit. We saw one person exploring the trampoline on the day of our visit in the hope that with time they will be able to use it.

There is an internal courtyard space that can be accessed from various areas of the service including some peoples' bedrooms. We could see that there had been work done by people in the art and gardening groups to brighten this space, by painting some of the bricks and planting pots with flowers and plants. Despite this, the courtyard was not particularly welcoming, consisting of brick walls and concrete.

There is a garden space surrounding the building and a summerhouse, that had previously been a visiting space during the pandemic; there are plans that this will be used for activities in better weather.

When we visited, we saw that some people had made their bedroom spaces very personal and homely, with pictures on the walls, lots of personal possessions and preferred bed linen. Other people had sparse rooms with minimal personal possessions, and this reflected their own preference and how many things they could manage having in their own space. People had 'About Me' information on their bedroom doors, with their likes and dislikes. People could also choose whether they wanted their windows covered with privacy film or not. Some people did not like the privacy film and could become distressed by it. Others had dark privacy film, which was helpful in keeping their rooms dark at night when they were trying to sleep.

All the bedrooms and many of the en-suite bathrooms were plain, outdated, and stark. There was little in the way of homely soft furnishings or colour. In some rooms, the privacy film was peeling from the windows. There were no curtains or blinds, which only added to the lack of a homely feel, although we were told that integral blinds had been fitted to the self-contained flat and there was ongoing work as to whether all the bedrooms in the pods would have anti-ligature curtains or integral blinds in the future to improve the bedrooms, whilst also ensuring that people were not at increased risk of self-harm with ligatures.

The lounge areas in the pods were small rooms at the end of the corridor, which only had room for a row of sofas and chairs in front of the windows and a television. The nursing staff had a desk in the lounge area that meant that they were sitting with people rather than behind a door in a separate office; we could see activity timetables for everyone next to the desks. There was little usable space in the lounge areas, which were plain, featureless, and not welcoming.

In some pods, we could see areas that were in need of plastering and painting, particularly in high use areas, for example around a bedroom door where the plaster had crumbled away.

It was good to see then that people could use other larger spaces in the service. We could also see that there was a range of art and activity information evident in the main corridor, which included pictures about the animation club, progress towards the activity challenge and a timetable of activities for the week, with colourful artwork.

Blythswood House was not originally planned as an assessment and treatment unit for people with learning disability and this is evident. Whilst efforts have been made to make as much use of the space as possible, it is clear that the building is not fit for purpose.

In addition, the building is outdated, far from homely, and in need of ongoing maintenance and decoration.

Recommendation 1:
Service managers should ensure that a programme of works is progressed to update and redecorate the service so that it is bright, welcoming, and homely. This should include maintenance of damaged areas of the service, progress with regards to privacy film being replaced with either curtains or integral blinds in keeping with local risk assessments, updated furniture where needed, and the use of colour and decoration to make the space feel less clinical. Involvement of the service user group would be valuable in such processes.

Recommendation 2:
Senior managers should review alternative service models given that the current building is not fit for purpose and consider how a new model may be achieved.

Summary of recommendations

Recommendation 1:
Service managers should ensure that a programme of works is progressed to update and redecorate the service so that it is bright, welcoming, and homely. This should include maintenance of damaged areas of the service, progress with regards to privacy film being replaced with either curtains or integral blinds in keeping with local risk assessments, updated furniture where needed and the use of colour and decoration to make the space feel less clinical. Involvement of the service user group would be valuable in such processes.

Recommendation 2:
Senior managers should review alternative service models given that the current building is not fit for purpose and consider how a new model may be achieved.

Good practice

We were impressed at the amount of work that had gone in to making progress towards discharge for many of the people in Blythswood House and hope to see further progress for those where there are currently no discharge options.

The change in practice with a strong focus on team working, reflective practice, responsive care, and strong leadership is positive.

The focus on ensuring a range of meaningful activities is impressive and it is valuable to see the positive impact this has had in reducing periods of distress and the use of restrictive interventions.

The re-establishment of the service user group and the activities through this group are also great to see.

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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