Mental Welfare Commission for Scotland

Report on announced visit to: Rowanbank Clinic, 133c Balornock Road, Glasgow, G21 3UW

Date of visit: 20 June 2024

Where we visited

Rowanbank Clinic is a medium secure facility, providing forensic services to the West of Scotland. It also provides the national medium secure service for individuals with learning disabilities.

On this occasion we visited all eight wards in the Rowanbank Clinic:

Elm, a 10-bedded facility that supplies admissions facility for males.

Hazel, a 10-bedded rehabilitation facility for males.

Elder, a four-bedded facility and Sycamore, a six-bedded facility; jointly these wards host the national medium secure service for females with learning disabilities and mental illnesses.

Pine, a 12-bedded rehabilitation facility for males.

Cedar, a 12-bedded rehabilitation facility for males.

Holly, an eight-bedded national medium secure service for males with learning disabilities.

Larch, a 10-bedded rehabilitation facility for males.

On the day of the visit, the capacity in Elder had been reduced to two beds and Sycamore to three beds, to manage patient acuity.

We last visited this service in August 2023; we made recommendations to improve the consistency and completion of nursing care plans, and to improve staffing levels to minimise any disruption to individuals' care and support their access to activities in the wards and whilst out on pass in the community. We were subsequently informed by managers that these matters had been addressed and actioned by the service.

For this visit we wanted to follow up on our previous recommendations and to review those new to the service, those subject to soft mechanical restraint, those awaiting discharge to a lower level of security, as well as those who had made excessive security appeals.

Due to the announced nature of this visit we were able to speak with relatives and individuals. Since our last visit we have received a number of communications that have helped to inform the themes we focused on during this visit.

Who we met with

Prior to the visit, we held virtual meetings with the senior charge nurses (SCNs), the lead nurse, the professional lead for psychology, the operational safety co-ordinator, the lead for allied health professionals, the nurse consultant, the service managers, the clinical director for forensic services and the advocacy manager. On the day of the visit, we met with the nursing staff on each of the wards we visited.

We met with 25 individuals and undertook 18 file reviews into their care and treatment. We carried out a further six file reviews into individuals' care and treatment. We met with and spoke to five relatives of individuals in the hospital.

Commission visitors

Justin McNicholl, social work officer

Gemma Maguire, social work officer

Anne Craig, social work officer

Kathleen Taylor, engagement and participation team manager

Mary Leroy, nursing officer

Mary Hattie, nursing officer

Paul Macquire, nursing officer

Douglas Seath, nursing officer

What people told us and what we found

At the time of our visit to the wards, there were 63 individuals in Rowanbank Clinic, which can accommodate up to 74. During our meetings with individuals, we discussed a range of topics that included their legal status, contact with staff, individuals' participation in their care and treatment, activities available to them and their views about the environment. We were also keen to hear from individuals who had been in Rowanbank Clinic for a short period of time, to understand how they were being supported with their move to a medium secure hospital.

We were able to visit or observe individuals in all of the wards. The majority of the individuals that we spoke with in Holly, Larch, Hazel, Cedar, Pine, and Sycamore Wards were very positive regarding the care they were receiving from a variety of staff. Some of the comments we heard were "I was dreading coming here, but two months on, the staff have helped to reduce all my anxiety" and "this is the best hospital I have ever been in, the staff are amazing".

This view was echoed by a relative that stated, "I'm glad he is there, the staff know him and treat him so well" and "we can't fault any of them, they all do such a great job." Individuals informed the Commission visitors that the ward staff had provided person-centred care which made them feel "brilliant" and as a result, one person expressed "this place is amazing and I am treated as a human being here".

Individuals on Elm Ward, the assessment ward, gave positive feedback on the groups and activities delivered by occupational therapy staff, which we observed during the visit. Individuals stated that the activities help to motivate improvements in their mental health. We heard directly from a various individuals across the wards about the range of recreational groups that offered exercise and sports which individuals enjoyed and benefited from.

We were not able to speak with any individuals in Elder Ward during this visit but hope to do so during our next visit.

Since our visits in 2021, 2022, and 2023 staffing pressures throughout the clinic have been one of the key issues that individuals wanted to speak about. During this visit we heard from an individual stating, "the staff do their best to keep the outings going but they often get moved to cover elsewhere; it happens regularly, sometimes three or four times in a row. I had to have my appointment changed as there was nobody to escort me". Although we heard this from one person, many told us that their care, treatment or outings were not compromised by a reduced staffing provision.

Managers advised us that, similar to our previous visits, there has been an ongoing recruitment drive to address the number of vacancies across all wards, and the clinic continues to use bank staff across NHS Greater Glasgow and Clyde (NHS GGC) to

support the service. We were advised that over 20 new staff were expected to start in the clinic in the coming months, which should ease the pressure on the service.

Managers spoke of how by later in the year the staffing complement will have improved to pre Covid-19 pandemic levels. Due to the demand for nursing staff across the sector, managers at the clinic have over recruited to healthcare assistant posts to ensure that there is a complement of staff available to deliver key roles in the absence of nursing posts. During the visit the clinic was well staffed with no evidence that rehabilitation activities in the clinic, community, or in the community centre were affected. We noted that there has been no agency staff used in the clinic.

We were advised of a small number of staff vacancies in psychology, psychiatry, physiotherapy and dietician posts due to sickness, maternity leave, or reduced working hours. Despite these vacancies we heard of the steps taken by managers to cover these absences. The majority of allied health professional (AHP) posts were filled, which was reflected in the positive feedback we received from individuals and families when it came to discussing the therapy input and activities.

We spoke with a number of individuals who were either in a higher or lower level of security prior to their move to the clinic. Many expressed that they were clear plans for their next move on from the clinic and they praised the staff for the “support”, “compassion” and “dedication” given to achieve their recovery. One commented, “I found it hard to adjust from the regime at the State Hospital. Sometimes the staff think I don’t like them. It's me coming to terms with the change. In the State Hospital the bad outweighs the good but it's the opposite here. All staff are approachable and if you have a problem, you can always go to someone".

From the relatives that we spoke with, many commented on the “welcoming and helpful staff”, their “willingness to promote recovery” and “kindness” that was shown.

Some found that on occasion, a "one size fits all" approach was adopted in the clinic which was “not always helpful” and resulted in those individuals struggling with “the set routine and rules”. Some spoke of how it would be beneficial to have “a clear and consistent induction pack” for relatives/carers, as some found themselves learning from staff or other relatives about the restrictions and allowances in the clinic. There were comments received that the forensic services would benefit from publishing information booklets that “provide a clear pathway for individuals and their relatives on the move through forensic services”.

We heard from some relatives regarding their annoyance that those subject to assessment orders or treatment orders were “stuck”, awaiting the actions of sheriff courts, the procurator fiscal office or lawyers. This delay was noted to be causing both relatives and individuals unnecessary stress and anxiety, which they could do

little to influence. We signposted and advised these individuals to discuss this with their lead clinician to support them with the challenges they face.

We heard from a number of relatives that they were not signposted as to how they could engage with the lead psychiatrist and found them to be “hard to reach”. There were reports that psychiatrists were left messages, but relatives/carers told us these were not responded to which left them feeling, “lost”, “confused” and “uncertain of how to discuss valid issues”.

This was echoed by some individuals who told us that their solicitors had written to their psychiatrist and had not received a response. We appreciate that psychiatry staff are busy due to the complex and demanding nature of their roles, however the feedback identifies that action is needed to assure relatives and to ensure that external professionals are made aware of how best to share information, discuss concerns or answer questions (if possible) that they have in a timely way.

We were pleased to note that compared to our last visit, we heard no concerning comments regarding the impact of GEOAmey who provide transport for those individuals attending court.

Care, treatment, support and participation

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care and intervention; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

When we last visited the clinic we found inconsistencies in the frequency of care plan reviews, with some having not been reviewed in several years. During this visit we found a significant improvement in the recording of the care plans and their content. Since the recommendation from our last visit, managers and staff have worked together to ensure that care plans have been completed and audited. The clinic has introduced, in the paper notes, a new index section which aims to streamline the care plan process that sits alongside the information held on the electronic record system, EMIS.

On reviewing the care plans, we saw that the individuals in the clinic had a wide range of complex mental and physical health needs. We found that all individuals had multiple plans to support all aspects of their care and treatment in the hospital. We found the majority of care plans focused on supporting admission goals, outcomes and identified plans of nursing care. The information in these plans detailed what the individual required, provided a clear understanding for staff to know what nursing intervention was necessary to provide the support.

The information in the care plans were person-centred, with a focus on recovery to support discharge. We saw evidence of reviews of the care and treatment plans, with the majority of the reviews being sufficient; they provided a summative evaluation of individuals' progress.

We found that the care plans were reviewed on a consistent basis and were commented on at the multidisciplinary team (MDT) meetings. We found that a few of reviews were basic in their content but overall, this was a significant improvement compared to our previous visit. The new process has clearly improved the quality of care plans, and all staff should be praised for their efforts in addressing the Commission's recommendation.

Care records

Information on patients' care and treatment was held in three ways; there was a paper file, the electronic record system EMIS, and the electronic medication management system HePMA. Care plans and nursing reassessments were held on the paper system. MDT reviews and daily notes were held on EMIS, along with legislative paperwork. The health board is in the process of transitioning across to a fully electronic system however no date has been agreed as to when this will commence in the clinic.

We found the care records to be well organised, easy to navigate and allowed all professionals the ability to record their clinical contact in the relevant sections of each individual's file.

All individuals across the hospital were subject to the Care Programme Approach (CPA). This approach was co-ordinated by staff onsite and ensured that meetings for individuals took place regularly and were recorded in a consistent way. There was evidence of individuals, relatives/carers and advocacy staff participating in these meetings, as well as mental health officers and social workers. Risk assessments and management plans were also found in the care records.

Multidisciplinary team (MDT)

The use of regular MDT meetings ensure that all professionals, individuals, and relatives are aware of what care is planned. Each consultant psychiatrist for the various wards held weekly MDT meetings. Each individual met with their key nurse before the meeting and discussed any issues, or questions they want to raise at the meeting. The meeting was recorded on a structured MDT meeting template.

We found detailed recording of the MDT discussions, decisions and personalised care planning for individuals. We were pleased to see clear links between MDT discussions and the care plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission.

The MDT had a broad range of staff providing input for each individual. These included medical staff, nursing staff, occupational therapists, psychology, and pharmacy. Each member of the MDT provided care and treatment specific to their expertise and provided weekly feedback at the meeting. We found evidence of who attended the MDT, and this was generally consistent across all wards. We heard that the MDTs mostly took place in person, which provided easy access for staff and when applicable, for individuals. During this visit, we did not hear any issues or concerns from patients about their attendance at the MDT meetings.

Use of mental health and incapacity legislation

Individuals at the clinic are subject to restrictions of medium security; all patients require to be detained either under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act).

The individuals we met with during our visit had a clear understanding of their detained status. All individuals that we met with, where applicable, reported that they had advocacy support and legal representation. All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act, 2000 (AWI Act), 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. Medication was recorded on the hospital electronic prescription management application (HePMA) and replicated what was recorded on the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act.

We found one T2 form which did not correspond with the medication being prescribed and followed this up with the staff on the day. The rest of the forms that we reviewed were completed by the responsible medical officer (RMO) and were found to be up-to-date.

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

For those people that were under the AWI Act, we found documentation, including powers granted and details of proxy decision makers. Where an adult does not have capacity in relation to any welfare or financial decisions, such as agreeing to medical treatment, care and/or support, the need for legal safeguards should be fully considered by the MDT to ensure rights are protected. This may include the need for

a section 47 certificate, a power of attorney or guardianship order, complete with a clear recording of discussion, agreed actions and review. We found a number of EMIS and paper notes throughout the recordings that used the phrase 'subject to AWI' when referring to financial and/or welfare matters.

When we made enquiries with staff regarding their understanding of this, there was confusion and a lack of knowledge. To prevent confusion, we would advise that the relevant sections of the AWI Act are clearly recorded and referred to specifically in all documentation. We shared with managers our latest learning resources on Turas which the Commission developed in partnership with NES to support all staff in promoting rights in the application of AWI Act. Due to the lack of a consistent approach deployed in the wards, we are recommending that training for staff around all aspects of AWI Act is considered and the current process is reviewed to ensure that the terminology is improved, so that staff and individuals are clear and consistent about what powers and provisions are being utilised for individuals across all wards.

Recommendation 1:
Manager should ensure that there is clear and consistent recording of which section of the AWI Act is being applied.

Recommendation 2:
Mangers should review staff training around the use of the different areas of the AWI Act.

Rights and restrictions

Due to its medium secure status, Rowanbank Clinic operates a locked front door to the reception area of the building, along with an airport-style security checks for all visitors. All wards operate a locked door policy which is commensurate with the level of risk identified with the individual group.

Some of the individuals we met with were subject to enhanced levels of observation. Of these individuals, some were being nursed in their bedrooms for the safety of themselves or others. All the observations that we witnessed on the day of our visit were being delivered to a suitable standard and in line with good practice.

We were pleased to hear that the level of soft mechanical restraint (SMR) in the clinic appears to have reduce in frequency over the last few months due to improved mental health presentation of some individuals. The Commission is required to be informed of all use of SMR, and we reminded the service to maintain these notifications.

Since our last visit, there has been a significant incident in the clinic. Due to the circumstances surrounding this incident there has been a significant adverse event

review (SAER) undertaken to look at the events leading up to the harm. We will await a copy of this report before making any further comment on whether any further action is recommended. We heard from managers of the steps taken to minimise any further similar incidents of harm occurring.

Advocacy in the clinic is delivered by Circles Advocacy. The feedback on the advocacy service was very positive and this was noted during several of our meetings with individuals. One stated, “she is always around, here to help and gets my views heard, without her I don’t know what I would do”. The consistent and flexible advocacy service input to the clinic was noted at various meetings held throughout the service. Individuals reported to us that they found the advocacy service to be very helpful, responsive to their needs and described it as “easy to access”. We met with the advocacy service manager and heard that it was a well-used and valued service. We noted that there are regular drop-in sessions in many of the wards, arranged by the advocacy service. We saw from the care records that advocacy attended the ward regularly and supported individuals who were involved in tribunals, in their discharge planning and CPA meetings.

When we are reviewing individuals’ records, we look for copies of advance statements. The term ‘advance statement’ refers to written statements made under sections 274 and 276 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. On this visit we found were appropriate advance statement in place, and where individuals had completed advance statements, these were easily accessible. The success of ensuring a significant number of advance statements was due to the work undertaken by advocacy services to promote this important safeguard. During some of the meetings with individuals, their advance statement was revisited and checked by advocacy staff to ensure the views recorded were still accurate.

Bed capacity in the hubs was not an issue on the day of our visit. The exact number of individuals waiting on a move to a lower level of security changes regularly. We heard that at the time of this visit, there were eight individuals waiting to move to a lower level of security.

During the visit, we found there were a number of individuals who were in conditions of excessive security. Due to the wait for a lower level of security, some individuals had appealed to the Supreme Court, the appropriate legal route to escalate these matters. The Commission remains concerned that the rights of these individuals to move are not being met, and we will continue to follow up on individual cases, as appropriate.

The Commission has regularly highlighted the significant difficulties with regard to ‘individual flow’ across the forensic estate. The situation of individuals in the hospital

waiting on a move to a lower level of security remains an issue that continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review. The Commission has produced *Appeals against detentions in conditions of excess security* good practice guidance.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment.

Activity and occupation

Given the nature of clinic as a medium security facility, most of the activity for individuals is in the clinic. Most individuals told us of a range of opportunities to attend a wide variety of activities, either on the wards or in the grounds and community centre. Most individuals we met with had free access to the enclosed clinic grounds and were able to join in activities such as football and attendance at the community centre. On-ward activities were mainly led by occupational therapists and nursing staff and included a mixture of one-to-one and small group activities. We received comments that one of the newly appointed occupational therapists was a "breath of fresh air". We received comments on the benefits of the cooking group, where individuals can purchase food and cook meals from fresh, with a specific focus on recovery and development of life skills.

During this visit we met staff in the community centre. This resource provides individuals with a variety of activities including access to the gym, prayer room, activities room, café, sports hall, meeting room, library, computer room and the communal space. The centre was praised by those who we met with, and we heard about the flexibility in finding activities that matched with individuals' interests.

During our visit to the centre there was a weight loss group taking place which was focused on promoting healthy eating and exercise. We heard about occupational therapy staff who assisted with arranging activities in the community centre and in the wider community.

We observed individuals working in the clinic greenhouse, which is managed by the occupational therapy service based at Leverndale Hospital. We were able to observe the facilities where cooking sessions, gym classes, football classes, and various other vocational activities were there to promote recovery and positive mental wellbeing. There was new gym equipment which we had heard about during our last visit and now appears to be helping individuals in maintaining physical exercise.

Some individuals told us that they believed they were too restricted by their legal status, that they we would prefer more freedoms and what they considered as more meaningful rehabilitation. We advised these individuals to discuss this further with

advocacy and the MDT so their views could be considered and acted upon if possible.

We were pleased to find each individual had a timetable that recorded a programme of activities related to their interests, assessed needs, goals and outcomes. We met with individuals who told us they spent a lot of time engaging in community activities and were supported by third sector agencies such as Glasgow City College. We heard, that in preparation for the Euro football tournament there was a 'cycle to Germany' activity in place, which staff and individuals were participating in.

We heard that there was no working kitchen in some of the wards due to how these had been designed and the use of the community centre was required to accommodate individual sessions.

Individuals greatly value activities in the wider community and in most cases, they require to be escorted by staff to attend these activities. Given current staffing pressures, outings are occasionally cancelled, although they are generally rescheduled soon after; when this happens individuals can be upset, and this issue was also raised by the advocacy service.

The physical environment

The physical environment of the wards was largely unchanged from our previous visit. One significant difference is the new purpose-built fence has been installed at the front of Elder Ward. The fence provides women in the ward more privacy from other wards. The garden area has been transformed to provide a peaceful, quiet space that enables exercise and an alternative environment, especially for those who are subject to enhanced levels of observation. We look forward to speaking to individuals during our next visit to identify if this change has improved their quality of life.

During this visit, we found the wards to be clean and tidy. Many of the individuals presented as relaxed and comfortable with the staff on shift. Each ward had a communal area that had a TV, soft furnishings and decoration to make it more homely.

Any other comments

Similar to our previous visits dating back to 2019, several individuals raised the issue of the food at the clinic. We heard the food is not good, individuals regularly do not get what they ordered and some of what is supplied was described as "uneatable". One of the particular difficulties in a restricted setting is that individuals have little in the way of alternative to what the hospital provides. Some individuals had taken it upon themselves to order front deliveries from local shops to address the poor standards.

Recommendation 3:
Managers should urgently address concerns raised about the food provided.

We received comments from several individuals that previously the clinic had a hairdresser who would visit the community centre. Unfortunately, this role has been vacated and there is currently no visiting hairdresser. Individuals spoke of not having enough free time in the community to have their haircut, so they relied on fellow patients to assist. We raised this with managers, who advised us of plans to have a new hairdresser in place as soon as possible.

While visiting Holly Ward, the contract that the clinic has with the building supplier means that they only paint certain walls at a time. The impact of this is that the ward has certain walls that look clean and modern, while others look tired and in need of repainting. This contractual arrangement would benefit from being revisited to aid the décor of Holly and other wards.

Summary of Recommendations

Recommendation 1:
Manager should ensure that there is clear and consistent recording of which section of the AWI Act is being applied.

Recommendation 2:
Mangers should review staff training around the use of the different areas of the AWI Act.

Recommendation 3:
Managers should urgently address concerns raised about the food provided.

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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