Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Edinburgh Hospital, Islay Centre and Carnethy House, Edinburgh, EH10 5HF

Date of visit: 22 August 2024

Where we visited

The Islay Centre is comprised of three units, with a total of 11 individualised areas that combine day/sleeping areas for individuals. In addition to this unit, Carnethy House provides a service for another two individuals. Both units are based in the grounds of the Royal Edinburgh Hospital. This service provides assessment and treatment for individuals with a learning disability, who have significantly complex and challenging behaviours, often associated with a diagnosis of autistic spectrum disorder.

On the day of this visit, there were 12 individuals in Islay Centre and two in Carnethy House.

We last visited this service in November 2023 and made recommendations in relation to the audit of care plans, a review of the psychology provision in the units, ensuring consent and authority to treatment was in place, a review of section 47 certificates, recording of enhanced observation, a review of the seclusion policy and addressing the environmental issues.

The response from the service was to consider using audit tools to support regular and effective auditing of care plans, as well as a new section in the ward multidisciplinary team (MDT) meeting template to review consent, authority to treat, section 47 certificates and the recording of enhanced observations. The service reported that review of medical and psychology provision had taken place, and a new consultant psychiatrist would start in the unit in September 2024; psychology recruitment was ongoing. We were advised that there were interim arrangements for medical and psychology provision until permanent measures could be implemented. In relation to environmental issues, the service responded that there would be ongoing communication with estates and senior managers.

For this visit, we wanted to follow up on the previous recommendations, meet with individuals, carers and staff as well as looking at the care and treatment being provided in both units.

Who we met with

We met with and reviewed the care of 10 people, eight who we met with in person and ten who we reviewed the care notes of. We also met with/spoke with four relatives.

We spoke with the clinical nurse manager (CNM), senior charge nurse (SCN), nursing staff, consultant psychiatrist, speciality doctor and discharge co-ordinator.

Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

Andrew Jarvie, engagement and participation officer (lived experience)

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

Comments from individuals

We were unable to have detailed conversations with some of the individuals, due to their significant communication difficulties as a result of their severe/profound learning disability. Some of the individuals who were able to verbally communicate told us “staff are very nice to me” and “staff help me every day”.

Some of the individuals were able to respond to our interactions by using non-verbal communication, such as smiling and using hand gestures, such as thumbs up. We observed some positive and compassionate interactions between ward staff and individuals during our visit and it was evident from these observations and discussions with staff that they had a good knowledge and understanding of the individuals they provided care and treatment to.

We were pleased to see progress in individuals’ circumstances from our previous visit. For one individual we met with, they were able to show us their progress in relation to activities they were engaging in, both in the unit and in the community. We also observed positive changes to the individual’s environment which supported a more therapeutic space for them to receive their care, treatment and support. We were encouraged to see the benefit these areas had had on the individual’s recovery and future planning.

We were pleased to find that staff had adopted their own individualised approach of communication with individuals, using a variety of different methods such as the use of signs and object signifiers. We observed that staff had a good understanding of the individuals’ sensory needs and responded in a therapeutic way to meet sensory needs.

Comments from relatives/carers

All of the relatives we spoke with reported that they were happy with the quality of the care and treatment their loved one was receiving in Islay Centre and Carnethy House.

We heard comments that “staff were fantastic”, there was “excellent staff communication” and “the team are making positive changes to my son’s life”. All of

the relatives that we heard from told us that the staff team were committed, supportive and provided consistent care. Relatives commented on the positive impact of care, support and treatment that the additional staff members and disciplines who were part of the MDT had made. We heard that relatives found the addition of the psychologist positive, and those who were involved in psychological formulations found them beneficial.

All relatives commented that they felt involved in discussions and decisions in relation to care and treatment of their loved one and that they had contributed to care planning meetings.

Concerns were raised with us about access to the unit minibus and the negative impact this had on their family member having the opportunity to use the bus for community outings. We raised this with the service on the day of the visit and were told that only one staff member had a licence to drive the unit minibus. We heard that it was not a requirement for staff to drive the minibus and that a barrier to staff volunteering to drive the minibus was related to insurance issues. The service agreed that the current minibus arrangements in place did not always provide benefit to the individuals however, they were unsure how to resolve these issues as it was not a requirement of the staff's role. The service will escalate this matter to senior NHS managers for their consideration.

Care, treatment, support and participation

Nursing care plans

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

Individuals in the Islay Centre and Carnethy House had various treatment plans relevant to their care goals which were held in paper files. The treatment plans we reviewed provided comprehensive and detailed information, reflecting the complexity of the care that was being provided in the units.

We found that 'Getting to Know Me' documentation had been comprehensively completed and provided personalised and person-centred information in the treatment plans. We saw some positive examples of each individual's participation in care planning which was supported by the use of symbols, signifiers, as well as input from speech and language therapy. We heard that NHS Lothian will be implementing new person-centred care plans in the coming months which will be recorded on the electronic record system, TrakCare.

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

We raised the concerns noted in our previous report in relation to regular or robust review of the treatment plans. We were disappointed that limited progress had been made with the review process and we therefore repeat our previous recommendation.

Recommendation 1:
Managers should implement a system for regular audit of treatment plans to ensure consistency in quality, recording and review.

We saw that while regular reviews were taking place, the information recorded following the review did not provide any detail as to whether any changes had been made and if so, there was limited information recorded on the rationale for changes.

As highlighted in the previous report, the care programme approach (CPA) and MDT meetings that record progress and the changes that had been made to care planning were not reflected or recorded in treatment plans. We were concerned whether the information recorded in the treatment plans remained relevant to the individuals' current care and treatment goals. We discussed the reviews with the CNM and SCN who recognised that improvements in the review process were needed. We heard that the unit had started to make plans to review all treatment plans and were told that the increased consultant psychiatry input to the MDT would support the review process.

The Commission has published a good practice guide on care plans[1]. 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.

Care records
Information on individuals' care and treatment was held electronically on TrakCare; we found this easy to navigate. The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Islay Centre and Carnethy House.

The care records we reviewed were of a good quality and evidenced person-centred, individualised recording, detailing the activities the individual had engaged in that day and what had been positive or challenging. We were pleased to see that the care records focussed on the strengths of the individuals. The strengths-based approach was also evident during more challenging circumstances, providing details after incidents of aggression.

We saw that all members of the MDT recorded in the care records and were pleased to see an increase in senior medical staff recording in care records.

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[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Most of the risk assessments we reviewed were detailed and provided comprehensive information on identified risks and how the individual would be supported to manage and minimise risk. In our previous report we had commented that some risk assessments had not been reviewed for a long period of time. We were pleased to see an improvement in the frequency of reviews in the majority of risk assessments.

CPA was in place for all individuals. The CPA documentation was of a high standard and evidenced MDT assessment, review, co-ordination of care and support needed for the individuals. We saw that where appropriate, individuals and family members attended the CPA meeting and were involved in discussion and decision-making. We were pleased to note that for some individuals, they were supported by advocacy to attend their CPA meeting.

We found that there was an improvement with the discharge planning process since our last visit. We heard that three individuals had been discharged in the last year and saw clear evidence of active discharge planning for other individuals in Islay Centre and Carnethy House. Where discharge planning was in progress, we saw that there was regular involvement from the MDT, the individual and where appropriate family and/or welfare guardian, community services and third sector providers. We saw that there were regular discharge and decision-making discussions recorded as part of MDT and CPA meetings.

We met with the discharge co-ordinator who told us that the dynamic support register, designed to help each health and social care partnership to know about people with a learning disability and complex needs in their area, had been completed for all individuals and had identified needs and barriers to discharge. We heard that there were individuals who were experiencing delays in their discharge, however we were pleased to see a decrease in these numbers from the last visit and the proactive approach to discharge planning.

Multidisciplinary team (MDT)
The units had a full multidisciplinary team (MDT) on site consisting of consultant psychiatrist, speciality doctor, psychologist, nursing staff, occupational therapy (OT) staff, speech and language therapy, and an art therapist.

We previously raised concerns over the level of medical provision provided in the unit. We heard that there had been a change in medical staff and that for a time limited period, the medical provision had been reduced even further. We were concerned with this information, although we were encouraged that the MDT had considered that the most effective way to use the medical provision available was to prioritise the consultant psychiatrist undertaking reviews of all individuals, and for the consultant psychiatrist to attend the MDT meetings and be part of the discussion and decision-making regarding the individuals’ care and treatment.

We were encouraged to see an increase in the one-to-one interventions/reviews between individuals and the consultant psychiatrist. We were pleased to hear that a permanent consultant psychiatrist was due to start imminently and would provide six sessions a week to the Islay Centre and Carnethy House, which was a significant increase. We were also encouraged to hear that the provision from the speciality doctor had been increased.

We were advised after our visit that the professional lead for psychology in the learning disability service currently provides two days of clinical input into the service. The psychologist works with the MDT to identify individuals who required psychology input as a priority and develops psychological formulations for these individuals.

Due to the limited amount of psychology time available, there are some individuals in the Islay Centre who would benefit from this input, in order to implement a PBS approach; this would be beneficial in facilitating discharge to less restrictive settings.

Funding arrangements for dedicated full-time psychology input have not yet been finalised and the Commission would support the develop of this permanent addition to the team to ensure that all individuals, and the wider staff team in the Islay centre routinely have access to psychology.

Recommendation 2:
Managers should urgently review the psychology input in the unit to ensure there is a long-term plan for an appropriate level of input to be in place.

The MDT meetings took place weekly, and each individual was discussed on a fortnightly basis. The MDT records we reviewed provided comprehensive details on all aspects of the individual's care planning. We heard that individuals and relatives/carers were invited to attend the MDT, although CPA meetings were better attended. Nevertheless, we saw examples of positive engagement with individuals and carers/relatives to gather their views. It was positive to see that all members of the MDT were involved and committed to adopting a holistic approach to individuals' care and treatment.

We were told that with the pending recruitment of nursing staff, both units would have a full complement of staff by September 2024. The senior management team have gone to great efforts to actively support recruitment and have demonstrated their commitment to ensuring both units had a full team to provide good quality care that provides support and treatment to individuals.

Staff we spoke with were happy in their role and commented that the addition of new staff made them feel more able to deliver improved high-quality care to the individuals they worked with; this made staff feel more confident and 'less stressed'

at work. We heard that having new members in the team had improved staff morale and the new skills and experience brought to the team was viewed as positive. We heard that some of the recent staff who have joined the team were newly qualified, but there remained a balance of experienced and skilled staff in the MDT.

Use of mental health and incapacity legislation

On the day of our visit, all of the individuals in Islay Centre and Carnethy House were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Many of the individuals were also subject to the Adults with Incapacity (Scotland) Act 2000 (AWI Act).

All documentation relating to the Mental Health Act was recorded on TrakCare and in paper files.

Part 16 (sections 235 to 248) of the Mental Health Act sets out conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

Medication was recorded on the hospital electronic prescribing and medicines administration (HEPMA) system. T2 and T3 certificates authorising treatment were stored separately on TrakCare. We reviewed the prescribing for all individuals. On cross-checking the electronic records for each individual, we again found errors with three detained individuals who were prescribed treatment without the necessary legal authorisation in place. We provided details of the individuals to the RMO and requested an urgent review.

Recommendation 3:
Managers and responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment, and that all psychotropic medication is legally authorised. Compliance with this should be audited.

On the day of the visit, we found the documented details for the welfare proxies and details of the powers granted in the welfare and/or financial guardianship order for those individuals who were subject to the AWI Act legislation.

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 found all individuals had a section 47 certificate in place with an accompanying care plan.

We reviewed one individual who had a covert medication pathway in place and found the relevant documentation was in place and had been reviewed as required.

Rights and restrictions

Islay Centre and Carnethy House continue to operate a locked door, commensurate with the level of risk identified with the patient group. Information on the locked door policy was available at the main entrance to the unit.

During the Commission's two visits, we highlighted high levels of continuous observations (CI) for many of the individuals in Islay Centre and Carnethy House. We were pleased to find that progress had been made in relation to the use of CI. We found that where this was required, this was proportionate to the assessed need and risk. CI was reviewed regularly by the MDT to assess its effectiveness and ensure the intervention was responsive, personalised and continued to be required.

Two individuals continued to be observed with the use of CCTV cameras in their rooms. We reviewed the care records of both individuals and saw a treatment plan detailing the requirement for the use of CCTV. We provided feedback to the service that for one of the individuals, we felt that the treatment plan should include more comprehensive detail on the purpose of the CCTV. We enquired if there were times that the use of audio and visual use could be reduced and also records could better reflect the level of staff intervention.

We discussed with the service that the disproportionate use of CCTV may be an intrusion into an individual's privacy and dignity which is protected by article 8 of the European Convention on Human Rights. The presence of a camera may be deemed a threat to individual privacy and must be proportionate, lawful and have a legitimate aim.

We were pleased to hear there had been a further reduction in the use of the seclusion rooms in the unit. We had previously highlighted our concerns that many individuals were secluded in their bedroom areas without seclusion care plans that should have been reviewed regularly. We were pleased to see a significant improvement in the completion and review of seclusion care plans for individuals where seclusion was used.

From our review of the care plans and records, we were able to see that where appropriate, the individual had engaged in meaningful activity with staff. We were pleased to see that the bedroom doors of the individuals we visited were open and the environment had a less restrictive feel. We did find that for one individual, they

were secluded in their bedroom area and there was no seclusion care plan in place that recorded the requirement for this practice. We raised this with the CNM and SCN on the day of the visit and requested this be reviewed immediately.

The Commission has produced good practice guidance on seclusion[2].

We were also pleased to hear that the level of restraint in both units had reduced. Islay Centre had a safety pod to use if restraint was needed and we heard that the safety pod promoted a more dignified, safe and compassionate approach to restraint for individuals who required it.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. We did not find any advance statements. It was evident from meeting individuals and reading their care records that they did not have the level of capacity required to make a valid advance statement. The Commission's good practice guidance on advance statements[3] is clear that the person making an advance statement has to have the 'capacity of properly intending' the wishes specified in it. We were pleased to see that the CPA documentation discussed advance statements and recorded whether an individual was able to participate in the making of an advance statement. We discussed with the SCN that it remained important that any wishes or views the individuals had were considered when making decisions regarding care and treatment.

Advocacy was provided by Partners in Advocacy. We heard from the individuals that we met with and staff in the units that advocacy support was easily available on the ward. We were pleased to hear and see that advocacy had regular discussion with the MDT regarding how best to engage with individuals to ensure the advocacy support was beneficial. We also saw that advocacy were supporting individuals who were involved in discharge planning and attending CPA meetings.

We were pleased to note that many of the files we reviewed recorded that the individual had legal representation. For those individuals unable to organise legal representation, a curator ad litem had been requested to safeguard the interests of the individual in proceedings before the Mental Health Tribunal for Scotland.

The Commission's *Rights in Mind*[4] pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

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[2] Seclusion good practice guidance: https://www.mwcscot.org.uk/node/1243
[3] Advance statements good practice guidance: https://www.mwcscot.org.uk/node/224
[4] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We heard and found evidence of a broad range of activities that were available for individuals, both in and out with the ward. The activities in Islay Centre and Carnethy House were mainly provided by the nursing staff, OT’s and the art therapist.

We were pleased to find each individual had an activity treatment plan and timetable that recorded a programme of activities related to the individuals’ interests, assessed needs, goals and outcomes. The activity treatment plan was person-centred and focussed on what activities supported admission outcomes and discharge planning. We were pleased to find many activity timetables included skill building and enhancement activities.

We saw from review of the treatment plans and care records that many individuals spent time engaging in community activities and were supported by third sector agencies. This additional support had been commissioned by social work to facilitate discharge planning, we were told by relatives/carers and staff that the support provided by the third sector providers was of significant benefit to support discharge and inclusion in community activities.

There were activity boards with details of various activities available in the units. Activities included outings to the local community parks, visits to the HIVE day service, visits from therapets and taking part in therapies, such as art psychotherapy.

We heard and saw that the service had purchased a new ground level trampoline which was located in the grounds of the hospital and that some of the individuals enjoyed engaging in this new activity opportunity.

We found the recording of activities was detailed, containing person-centred information on how the individual found the activity, what was positive for the individual and areas which they found challenging and where they needed support.

We saw that the activities were reviewed regularly with new activity opportunities offered to individuals following MDT discussion, input from individuals, relatives/carers and based on an assessment of risk. We were encouraged to see that staff provided consistent support to individuals that enabled to them to feel safe and confident when trying new activities.

The physical environment

The Islay Centre consisted of three units, Harris, Rhum and Barra. In addition to the Islay Centre, Carnethy House provided care for a further two individuals.

Each unit in the Islay Centre was accessed separately. Harris could accommodate three individuals, with Rhum and Barra units accommodating four individuals per unit. Each unit had individual ‘pods’ which included a bed space and en-suite

facilities. The pods varied in size with some having room for a small living area with a TV and sofa. Each pod had access to an outdoor garden area. There was also a communal garden that had flower beds and a water sensory area for individuals to use.

We were able to view some of the pods on the day of the visit and saw a variety in the environments. Some were personalised and therapeutic while others were more clinical. We heard that the individuals' environment was informed by a MDT assessment of the individuals' environmental needs.

We were told that the MDT aimed to create therapeutic and personalised environments for individuals where appropriate and in accordance with the needs of the individual.

When undertaking a review of the units, we noted that there was a high standard of cleanliness. We have previously highlighted our concerns in relation to the environment, specifically in relation to décor being refreshed and repairs being completed. We were pleased to see improvements to the décor, however the outstanding repairs remained an issue. It was also disappointing that plans for internal renovation which we had heard about during the last visit had not been progressed.

We remain concerned about the environments in both the Islay Centre and Carnethy House. We would expect to see an environment for people with a learning disability and autistic spectrum disorder consider the sensory needs of individuals, with facilities that enable individuals to maintain their daily living skills, such as a therapy kitchen and well-designed spaces that offer enhanced facilities for therapeutic activities. We will therefore repeat the recommendation from our previous report regarding the environment.

Recommendation 4:
Managers must prioritise addressing the outstanding environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Staff told us that many aspects of the environment were not suitable to provide a holistic approach to the care, treatment and to support the needs of the individuals in the units. However, staff remained motivated and committed to providing a high standard or care within the limits of the current environment.

Any other comments

The feedback from all relatives that we spoke with, in relation to the care and treatment provided to their family member, was very positive. We saw evidence of high standards of care during the visit that supported this feedback.

We were encouraged to find that some progress had been made and changes implemented since the visit in November 2023. We saw and heard evidence of good leadership in Islay Centre and Carnethy House provided by the CNM. In addition, it was positive to hear from all staff spoken to, that they felt supported by the current SCN. We were pleased to observe the positive working culture the SCN had promoted in the ward setting. It was evident that the ethos of the ward was a commitment to ensure and support staff to provide high standards of holistic, strengths based, and recovery focussed care.

Summary of recommendations

Recommendation 1:
Managers should implement a system for regular audit of treatment plans to ensure consistency in quality, recording and review.

Recommendation 2:
Managers should urgently review the psychology input in the unit to ensure there is a long-term plan for an appropriate level of input to be in place.

Recommendation 3:
Managers and responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment, and that all psychotropic medication is legally authorised. Compliance with this should be audited.

Recommendation 4:
Managers must prioritise addressing the outstanding environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

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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