Mental Welfare Commission for Scotland

Report on unannounced visits to: Wards 4A, 4B & 3A Leverndale Hospital, 510 Crookston Rd, Glasgow G53 7TU.

Dates of visits:

Wards 4A & 4B - 20 January 2020

Ward 3A - 22 January 2020

Where we visited

We made unannounced visits to wards 4A, 4B and 3A at Leverndale Hospital over two days. These are the adult acute mental health admission wards (primarily for patients aged 18-65 years) from South Glasgow. The wards are 24-bedded, mixed-sex wards; 4A and 4B are newer, purpose-built wards where all patients have single en-suite rooms. Ward 3A is an older style ward with a mixture of shared dormitories and individual side rooms.

We last visited this service on 29 and 30 January 2019. Our main recommendation at this time was in relation to the need to improve care planning documentation.

On the day of this visit we wanted to follow up on the previous recommendations and also have the opportunity to speak to patients and staff regarding patient care on the ward.

Who we met with

We met with and/or reviewed the care and treatment of 18 patients (six on each ward); no relatives were present during our visit. In addition we spoke with the nurses in charge of each ward.

Commission visitors

Paul Noyes, Social Work Officer

Lesley Paterson, Nursing Officer

Mary Leroy, Nursing Officer

Yvonne Bennett, Social Work Officer

Margo Fyfe, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The wards we visited were very different. Each had their own atmosphere and ways of working; the feedback from patients on all three wards was however very positive. Patients were aware staff were very busy but commented on how staff would always try to do whatever they could to help them and were approachable and respectful. Patients were aware of who their key nurse was, and they all received regular one-to-one conversations to discuss their care which were well-documented.

The three wards take patients primarily from specific geographical areas relating to local mental health resource centres. For most patients this provides a continuity, in that they have the same doctor managing their care both in the community and in hospital.

A common feature of all three wards was that they were full at the time of our visit and this is generally the case. The pressure on beds results in regular situations where patients have to 'board out' on wards not relating to their home area. This can be disruptive to both patients and staff. We noted this to be a particular difficulty on Ward 3A which had 13 patients 'boarded out' on the other two wards while awaiting a bed on this ward.

We heard that there had been recent changes in ward boundaries that had improved the situation for Wards 4A & 4A but may have impacted on Ward 3A patients. We would advise managers to keep this situation under review.

We were informed that the wards were mainly at full staffing levels with a relatively consistent staff group. A new senior charge nurse has just been appointed for Ward 4B and will take up post shortly.

On the day of our visit wards 4A and 4B both had one patient requiring an enhanced level of observation, and ward 3A had three patients requiring enhanced levels of observation. It would seem that ward 3A generally has more patients requiring enhanced observations and frequently need to supplement staffing levels using 'bank staff' to manage these demands. The reason for higher numbers of enhanced observations on ward 3A seems to relate mainly to the ward environment.

Each ward reported good medical cover with between three and five consultant psychiatrists covering each ward. One consultant on ward 4A is based in the hospital but the others work between the wards and the community. We heard from patients that they saw their doctors regularly and felt involved in their care. Staff said that the doctors visited the wards regularly, all held weekly multidisciplinary team (MDT) meetings to review patient care and were available by phone if needed. The high number of doctors working on each ward requires multiple MDT meetings but this does not seem to be causing difficulties.

The MDTs have input from psychology, occupational therapy (OT), physiotherapy, dietetics and pharmacy. Wards reported good contact with social work who attend MDTs as required. There are, however, a number of patients whose discharge from hospital has been delayed due to difficulties in finding accommodation; this appears to be a local difficulty. These cases

are being kept under close review and the service has a discharge coordinator who regularly meets with social work to address any difficulties.

Several patients told us they had received support from the 'money matters' worker in relation to benefits and finances. Patients also reported easy access to advocacy from the Advocacy Project which is also highly valued.

Though patients were reporting good care and treatment and being involved in their care, this was not always well-evidenced in patient records. The ward has recently moved to the EMIS electronic management system and notes were a mixture of electronic and paper records. We found patient progress notes on EMIS were generally good, with records of family involvement, participation in activities and good records of one-to-one contacts.

Care planning documentation - particularly on wards 4B and 3A - was, however, poor with care plans lacking in detail and personalisation. There have been efforts to improve care plans on ward 4A, but these plans still lacked the detail required. This documentation was still on paper files and it would seem improvements are on hold pending this being recorded on the EMIS system.

The Commission has raised the issue of the need to improve care planning on these wards in previous reports and this recommendation is repeated. Given that this issue has been raised previously the Commission. we will now escalate this for the attention of senior managers.

Recommendation 1:

Managers should ensure that care planning documentation is improved across all three adult acute wards to ensure that care plans address the specific needs of individual patients.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

On the EMIS system we found that MDT recording did not seem as comprehensive as it had previously been when in paper format. The recording lacked the structure and detail it previously had.

We were also concerned that risk assessment information was difficult to access, was inconsistent, and lacking in detail. Risk assessments appeared to be added on to the MDT meeting note rather than a being a comprehensive individual assessment.

Recommendation 2:

Managers should ensure that risk assessment and MDT recording is robust and not compromised by the move to the EMIS system.

Use of mental health and incapacity legislation

On all three wards, slightly more than half of the patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Patients we spoke to were clear about their status as were the staff. Detained patients had the required legal paperwork in their patient care files or on the electronic data system.

We noted on both wards 4A and 3A, for a small number of patients, there were issues regarding paperwork relating to treatment under part 16 of the Mental Health Act and the relevant forms authorising medication being prescribed. These were addressed with the senior charge nurse on the day and subsequently rectified. We would recommend an internal audit of these forms for all detained patients requiring such authorisation.

Recommendation 3:

Managers to review medication records for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act.

Rights and restrictions

We observed patients who, if they were able to do so, generally coming and going freely on all three wards; the doors to the wards were not locked and patients had easy access to the garden areas.

We observed on Ward 3A, where there were three patients on an enhanced level of observation, nurses were sitting outside of rooms with an apparent lack of therapeutic interaction with the individuals they were caring for. We raised this issue with the senior charge nurse on the day and encouraged practice to be reviewed in accordance with recent guidance for more therapeutic interventions - *From Observation to Intervention - A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care - January 2019*

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

A strength of these wards was the wide range of activities available to patients. There are two patient activity co-ordinators (PAC nurses) who provide input to the three adult acute wards. There is also joint work with the OTs and physiotherapists in relation to exercise; nurses also help provide activities for patients particularly in the evenings and at weekends. Patients able to leave the wards have access to the recreational therapy facility with the hospital grounds.

Patients spoke of a good range of programmed activity including various groups including; walking, relaxation, cookery, money matters, exercise and recovery.

The senior nurses informed us that there are due to be changes at the end of the month with additional activity nurses being employed at a lower grading allowing the higher graded activity nurses to take on more direct therapeutic interventions with patients. This is seen as a positive development.

The physical environment

The physical environment of these is unchanged from previous visits. Wards 4A & 4B wards are newer style wards where all patients have en-suite single rooms. Ward 3A is an older ward with a mixture of single rooms and dormitories accommodation. We heard if repairs are required they are responded to quickly. Ward 3A has been allocated funding for substantial redecoration which will be of considerable benefit to patients.

Though all the wards were very busy, they were calm and quiet. Several patients on Ward 3A said they liked the dormitory style accommodation on the ward as they enjoyed the company and support from other patients.

The acute adult wards have a shared dining area / visiting space which is not ideal. Meals have to take place in two separate sittings which can be frustrating for patients; the visiting area can get busy at times and is not particularly private. Staff often try to accommodate more private visiting in some of the smaller rooms on the ward if possible

All the wards have easy access to garden areas but these are not enclosed. This presents difficulties in the management of detained patients and can result an increased in the need for enhanced observations.

This was a mid-winter visit but garden areas were untidy and this environment should be improved.

Summary of recommendations

1. Managers should ensure that care planning documentation is improved across all three adult acute wards to ensure that care plans address the specific needs of individual patients.

2. Managers should ensure that risk assessment and MDT recording is robust and not compromised by the move to the EMIS system.

3. Managers to review medication records for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act.

Good practice

We spoke with one patient with a hearing loss on ward 4A and heard of the efforts that the ward had made to help this patient to get support in the tribunal process. We also heard of training for staff on Ward 4B that had been put in place to support them with recent issues in managing the challenges of psychoactive substance misuse.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

MIKE DIAMOND
Executive Director (Social Work)

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 MWC 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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