Mental Welfare Commission for Scotland

Report on announced visit to: Rehabilitation Ward, Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 15 December 2020

Where we visited

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. From August 2020 the Commission undertook a phased return to our visit programme following recommendations in the Scottish Government's roadmap to recovery.

We were keen to visit the rehabilitation ward at Leverndale Hospital as it had been some time since our last local visit and we had received some correspondence from patients and relatives.

This local visit was undertaken using a combination of telephone interviews and in person interviews on site at the rehabilitation ward.

The rehabilitation ward is an 11-bedded mixed sex ward providing intensive rehabilitation and recovery care and treatment to adults with severe and enduring mental health problems. Referrals generally come from acute inpatient wards. Patients can often be acutely unwell due to a relapse in their mental health and sometimes their motivation and engagement can be poor due to the chronicity of their illness.

On the day of our visit there were 11 patients, including one of whom who was boarding from the continuing care ward.

We last conducted a local visit to the ward in November 2015. At that time we were positive about the care and treatment people were receiving. We also visited there as part of our themed rehabilitation in mental health visit in 2018.

Following our 2015 visit we made recommendations relating to care planning and the physical environment, specifically the lack of a pinpoint alarm system.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and on the mental health of patients. We also wanted to give patients an opportunity to raise any issues with us and to ensure the care and treatment and the facilities are meeting patients' needs.

We also looked at:

- Care and treatment and service user participation
- Therapeutic activity and occupation
- Use of legislation
- Physical environment

Who we met with

We met directly with four patients, received written communication on the day from one patient, reviewed the care and treatment of five patients, and spoke with one set of relatives.

We spoke with the senior charge nurse (SCN), a charge nurse, a consultant psychiatrist, a junior doctor and a staff nurse.

Commission visitors

Lesley Paterson, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

We heard from staff and patients that despite the ward functioning as a 'Covid-19 red ward' during July and August, care delivery within the ward has continued very much as normal throughout the majority of the Covid-19 pandemic, with patients continuing to have good access to their psychiatrists, input from the wider multidisciplinary team, and advocacy services.

Psychology input has been taking place remotely, using 'Attend Anywhere' technology and some patients have managed better with this than others. We were pleased to hear that although subject to some ongoing restrictions, most patients have generally coped well with the experience of the ongoing pandemic and understand the need for the restrictions and change in practices.

One particular issue that has caused concern is the difficulty to discharge some patients during the last nine months. We were advised that this was, in part, as a result of measures put in place by the local Infection Prevention and Control (IPC) team to reduce footfall within clinical areas. Another factor affecting some discharges was where community based care providers restricted patients being able to view prospective placements or accommodation, due to their own local challenges. This has led to delays for some patients and although we are sure the position is being regularly reviewed, we are keen to hear an update from the service manager regarding the situation.

Care, treatment, support and participation

The patients and relatives we spoke to were generally very positive about the care and treatment provided by the clinical team. There is a diverse group of patients in the ward. Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their ability to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. We did however see evidence of considerable efforts by nursing, occupational therapy (OT), psychiatry and psychology staff to encourage engagement in both their treatment and activities.

The rehabilitation ward is well served by two part time consultant psychiatrists, a specialist registrar and a CT5 (junior doctor), with each consultant psychiatrist holding their fortnightly multidisciplinary team (MDT) meetings on alternate weeks. Although most of the medical staff are part time, we were told there is ample daily medical cover.

Due to the current Covid-19 pandemic the psychology service is being delivered remotely, however there was initially a problem with this as, until recently, the ward did not have Wi-Fi. We were told however that there was investment to ensure the essential technology was made available to support systems such as 'Attend Anywhere' and remote visiting for patients.

There is a visiting GP service and all annual health checks are carried out along with any other required monitoring including bloods for Clozapine therapy, lithium therapy, high dose antipsychotic monitoring and diabetic monitoring. There was evidence in the care records that physical health care was high on the clinical agenda. The ward has significant input from OT,

and physiotherapy and referrals are made to dietetics, podiatry and speech and language therapy if required. Pharmacy staff are available for consultation, completion of medication reviews, and will spend time with patients discussing their medication if this is required.

Patients are invited to attend the MDT meeting but some choose not to and instead will liaise with their consultant psychiatrist and nursing staff prior to the meeting to ensure their views are conveyed and then receive post meeting feedback. MDT meetings were clearly recorded within the care record and it was clear to see who attended and what the meeting outcomes/actions were. There was evidence of regular risk assessment and risk management contained within the records. Weekly community meetings take place and these allow for patients to discuss any ward based issues, concerns or views they may have. The patient's report that these meetings are useful, supportive, and they feel their views are listened to. The minutes for such are displayed on the ward notice board. There is also a communication board in the corridor where patients can leave their suggestions, comments or direct questions to the SCN, who will then respond to these directly on the board.

Patient records are stored in a combination of electronic notes (EMIS) and paper notes. It was clear from reading the records that staff knew the patients very well and care and treatment appeared to be individualised and appropriate to the current needs.

We had previously recommended that the standard of care plans be consistent in terms of personalisation. We were pleased to see there has been much progress in this area and were interested to hear about the new combined support plans which are being rolled out. These plans allow the patient to write their own care and treatment plan jointly with the MDT. For patients who identify their short term and long term goals, the Camberwell Assessment of Need is carried out and care plans are jointly written in response to these identified areas of need. We were impressed by these combined support plans as they appear holistic, comprehensive, involve all members of the MDT, were detailed in terms of physical health, mental health and social needs, and ensure the patient is held at the centre of their care and treatment. The care and support plans are reviewed at the MDT meeting and audited by the SCN on a monthly basis.

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

It was evident from the chronological notes and from talking to nursing staff that they actively promote and support family involvement in the patient's life and, where appropriate, in discussion of the patient's care and treatment.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. The Rehabilitation Ward staff have prioritised family contact and although the majority of visiting has been taking place over the telephone or by video call, each patient is currently permitted one designated visitor in the hospital grounds. Visiting guidelines will continue to be reviewed in line with current Scottish Government guidance. Carers and relatives information was displayed on the wall as you entered the ward.

We were informed by both patients and staff that advocacy input to the ward is very good as is the uptake.

Therapeutic activity and occupation

Every file we reviewed contained comprehensive OT functional assessments, reviews, structured activity planner, weekly activity programmes and OT care and treatment plans. There are a range of activities taking place on the ward including cooking groups, art and crafts groups, beauty sessions, socialising through games, weekly themed nights and, more recently a 'Come Dine with Me' themed event.

Attendance at the onsite Recreational Therapy (RT) department is currently suspended and we were told that patients are really missing the range of 'off ward' activities that are offered there. While there is no definite date for resumption of the department to its original way of operating, we have been advised that the RT service has adapted to offer a unique in-reach service. This allows both registered and non-registered staff from the RT department to provide patient indicated activity in the unit. The RT staff have a diverse range of skills and experience which promote treatment options and informs individualised combined care plans. This in reach service is reviewed on an ongoing basis by the service manager and team leads to reflect any changes made by Scottish Government in relation to the Covid-19 Pandemic.

In addition to the RT service, we were told that nursing and OT staff have been very creative in providing alternative ward-based projects. Staff compile weekly planners with each patient. There is an effort to fully involve the patient in these planners in order to empower them and hopefully maximise engagement. An activity board with the week's events in the ward was clearly displayed in the corridor.

When you enter the ward there is what the staff and patients refer to as a 'lockdown wall'. This was a really symbolic project between patients and staff where everybody came together towards the start of lockdown to paint whatever they felt was important and meaningful to them on a canvas. This resulted in a lovely display of all their favourite things, special memories and inspirational quotes. The project is viewed with pride by everybody involved and seems to inspire hope and the promise of brighter days to follow, after the Covid-19 pandemic.

Use of mental health and incapacity legislation

The majority of patients are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

We were pleased to see that all legal documentation was well maintained within the patient files and we did not find any issues with regard to T2 and T3 forms which authorise prescribed psychotropic medication. Additionally, section 47 certificates, treatment plans and spending plans under the Adults with Incapacity (Scotland) Act 2000 were in place where required.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests. That person is called a named person. Where patients wanted to nominate a named person we saw records of this in the patients file.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. Only one patient in the rehabilitation unit had an advance statement. When we asked nursing staff about this we were told that for different reasons patients don't really seem to bother with them. We were advised that ongoing work with the Rehabilitation Admission Pathway, will help address this. The pathway highlights each step of the admission process, ongoing care and treatment as well as the discharge process; it identifies the role each member of the MDT has in the patient's journey. The pathway will be reviewed to ensure that the status of an individual's Advanced Statements is clarified upon admission / transfer to the unit, and that as part of combined care planning the individual patient preferences are recorded. The combined care plan acts as a prompt for MDT Review and so will be considered on a regular basis.

We look forward to seeing evidence of advance statements being promoted through the pathway, the care plan and the MDT review. The Mental Welfare Commission has produced advanced statement guidance which can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf

Recommendation 1:

Managers should ensure that advance statements are promoted in the ward and clearly documented in the patient's pathway and care plan.

The physical environment

The ward initially moved to its current location in 2014 in what was described at that time as a temporary move; however, at some point the decision was made for it to remain there.

During our last visit staff acknowledged that although the ward was adequate, it was far from ideal. Unfortunately there has been little remedial work and it appears to us that certain aspects of the layout and composition is unfavourable.

The accommodation comprises of a four-bedded female dormitory, a four-bedded male dormitory, each with a shared shower and toilet and three single bedrooms, two of which have en suite facilities and the patient in the third room has to use the communal shower and toilet facilities in the ward corridor.

Many wards across NHSGGC have been refurbished to provide patients with individual en suite rooms and we would strongly encourage managers to consider the same here to ensure privacy and protect dignity, especially given the fact that this particular group of patients can be in hospital for fairly lengthy periods of rehabilitation. This view was echoed by some of the patients we spoke with, who commented that they just never seem to get any privacy or opportunity for quiet time.

We were informed of feedback about the environment that had been received from patients, relatives and staff, as well as from the output of mapping exercises required for the Royal College of Psychiatrists Accreditation process. This has allowed the service to identify areas for improvement, including small projects such as ensuring home furnishings, wall art, personalised boards, etc. There has been positive feedback to the ward as a result of these improvements. We heard that further work had been identified prior to the pandemic, and that the service manager will look to continue when current measures change to permit environmental improvements within the rehabilitation unit.

Due to the ward layout, it was evident that there are 'hidden areas' which cannot be easily observed by staff and various ligature points, partly due to the dated fixtures and fittings. We heard that there is ongoing work in relation to reducing the risk of self-harm, acts of suicide or attempted suicide in the mental health inpatient facilities across NHSGGC. The suicide environment design group in conjunction with Health and Safety have developed a self-harm control checklist (Environmental), which is designed to assist local managers and staff in mental health inpatient facilities to assess and identify any environmental features within their clinical areas which may be used by patients to harm themselves. This tool, in conjunction with local self-harm risk assessments are used within the rehabilitation unit, are regularly reviewed and any identified risks are actioned and / or escalated to the Service Manager and beyond as necessary.

The ward benefits from a number of communal areas including a spacious sitting room, a dining room, a large therapy dining kitchen, several smaller sitting areas and a private garden space. We noticed that the décor throughout looks tired and would greatly benefit from being painted; however, despite this, the ward environment was clean, tidy and free from any unpleasant odours.

There is a paved garden area attached to the ward which is an added resource for patients and it seems some of the patients take full advantage of the outdoor space, including maintaining the flower beds, planting seeds and tending to plants. When you first enter the ward there is what the staff and patients refer to as a 'lockdown wall' where the patients painted whatever they felt was important to them on a canvas, resulting in a lovely combination of their favourite things, inspirational quotes and things that make them happy.

Recommendation 2:

Managers should ensure that the ward environment is upgraded to create a conducive setting and that consideration be given to single room accommodation.

Recommendation 3:

Managers should ensure that assessments of the ward layout, particularly with regards to difficult to observe areas and ligature points, are actioned.

Any other comments

Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment, creativity and finding new ways of working. We were impressed with the way in which this service has adapted and it is hoped the positive changes that have benefitted some aspects of patient care can be continued and developed in future models of care.

Summary of recommendations

1. Managers should ensure that advance statements are promoted in the ward and clearly documented in the patient's pathway and care plan.

2. Managers should ensure that the ward environment is upgraded to create a conducive setting and that consideration be given to single room accommodation.

3. Managers should ensure that assessments of the ward layout, particularly with regards to difficult to observe areas and ligature points, are actioned.

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.

Alison Thomson
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 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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