Mental Welfare Commission for Scotland

Report on announced visit to: Leverndale Hospital, Ward 2, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 13 May 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Route Map (May 2020). There have however been periods during the pandemic where we have been able to conduct our face-to-face visits. This local visit was able to be carried out face-to-face.

Ward 2 is a 15-bedded mixed-sex ward comprising continuing care beds for patients with severe and enduring mental health problems. Many patients also have chronic physical health problems. Ward 2 is managed as part of the rehabilitation service in Leverndale. The ward has six single rooms and two four-bedded dormitories. The current patient cohort age range was from 45–89 years old and referrals tend to come from other wards on the Leverndale site.

We last conducted a local visit to this service on 15 December 2016, but also visited in 2018 as part of our themed visit to rehabilitation wards in Scotland. Following our 2016 visit, we made recommendations in relation to the way in which the service gathers patients' views on their care and treatment, maximising the use of the therapeutic kitchen, patient funds, and associated activities and patients' bedrooms.

We were keen to visit Ward 2 as it had been some time since our last local visit and we had received some correspondence from patients and relatives. On the day of the visit we wanted to follow up on the previous recommendations and also find out 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 to give patients an opportunity to raise any issues with us and to ensure the care, treatment and facilities are meeting patients' needs.

We also looked at:

- Care, treatment support and participation;
- Therapeutic activity and occupation;
- Use of mental health and incapacity legislation;
- Physical environment.

Who we met with

We met with and reviewed the care and treatment of five patients and spoke with two relatives and one friend.

We spoke with the senior charge nurse (SCN), the charge nurse, and other members of nursing staff on the day.

Commission visitors

Lesley Paterson, Nursing Officer
Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients and relatives we spoke to did not raise any specific concerns about the ward and were very positive about the care and treatment provided by the nursing staff, the psychiatrist and the allied health professionals.

We noted there is a very 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 mental illness means their motivation to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. However we saw great efforts by staff to encourage involvement in both their treatment and activities.

Many of the patients have physical health issues and mobility problems; some had significant physical life limiting illnesses. There are particular challenges in providing care for such a diverse group of patients and meeting their very different needs. Nursing staff told us they feel they receive a good level of support from medical staff and have also had access to additional training to meet the complex needs of their patient group. All patients have annual health checks and we saw evidence in the records of good attendance to physical health needs.

Some of the patients on Ward 2 have in place DNACPR (do not attempt cardiopulmonary resuscitation) orders. The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

'Do not attempt CPR' forms were completed with evidence of discussion with nearest relative or proxy as appropriate; however, not all of them had been reviewed within the requisite timeframe stated on the form, nor were all staff on duty completely aware of which patients were subject to the DNACPR policy.

It is fundamentally important that all relevant healthcare staff involved in the patient's care are aware that a decision not to give CPR has been made and documented on a DNACPR form. This not only ensures that CPR treatment in not erroneously withheld, but also that inappropriate, contraindicated and/or unwanted attempts at CPR which are of no benefit and may cause significant distress to patients and families is not attempted.

Recommendation 1:

Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

We saw evidence of good multi-disciplinary team (MDT) input. We heard that medical provision is good, as is the input from occupational therapy (OT), physiotherapy and pharmacy. Patients are referred to dietetics, podiatry and speech and language therapy if indicated. We heard there is currently no regular psychology input into Ward 2; however this service can be provided on a referral basis if required. There is a weekly MDT meeting which key members of the team attend. It was clear to see who attended each meeting and the summary of discussion and action points were clearly documented. There was also evidence of patient and carer involvement, with most patients choosing to attend the meeting.

Care plans were person-centred and detailed in terms of mental health, physical health and social care needs. We saw OT and physiotherapy assessments where appropriate. We were pleased to see that there are regular reviews of care and treatment plans recorded in both the MDT paperwork and in the chronological notes. It was evident that the staff really know the patients and are invested in working closely with them to ensure the best outcomes. There was evidence that the MDT continued to consider any possible alternative placements, even for those patients have been in hospital for long periods of time or for those who had experienced previous placements breaking down.

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

Chronological notes evidenced regular one-to-one discussions between the patient and nursing staff, and it was clear that the patients' views on their care and treatment were sought. Additionally, staff actively promote and support family involvement in discussion of the patient's care and treatment and historically have provided additional opportunities for family contact through social events such as Halloween and Christmas parties. The recent pandemic had an obvious impact on engagement with families and carers; however, there were concerted efforts to ensure contact was maintained, initially via telephones and i-Pads, and more recently visiting has been able to resume, in line with Scottish Government guidelines.

We were told that advocacy services can become involved with those patients who require it, however sometimes obtaining an appointment can be difficult, especially if the patient is not detained under the mental health act. From further discussions with staff it is hoped that this issue shall ease as we emerge from the Covid-19 pandemic, however staff have advised that they will escalate the matter if there are any ongoing issues with accessing advocacy for all patients, regardless of detention status.

Therapeutic activity and occupation

It was clear that the pandemic has had an impact on the broad range of external activities patients within mental wards can access, however it was evident that OT and nursing staff in particular have been instrumental in ensuring the continued delivery of a range of therapeutic, social and recreational activities on the ward. This includes breakfast and lunch groups, art and craft groups, walking and exercise groups, reminiscence groups, cinema nights, football groups, Tai Chi and various music groups both in the ward and via Zoom. There are also opportunities for outings out with the ward, when appropriate and the ward has access to its own transport. Although patients could not access the Recreational Therapy (RT) Department on the Leverndale site, the RT staff instead provided in reach to all of the wards. This input was well regarded by both patients and staff throughout the pandemic. We were also told that a new nurse activity co-ordinator is due to start soon and look forward to seeing how this improves the patient experience at future visits.

Activities were recorded in the patient's chronological record of care and the ward also had an activity board plan which detailed the activities that were due to take place each day. Each patient also had a copy of their personal weekly planner. Although there were patients who were reluctant to participate, we saw successful efforts to engage with them with positive outcomes for the individual.

When we visited in 2016, we highlighted our concern regarding the underuse of the therapeutic kitchen in the ward which at that time was only used once per week by the OT and was otherwise locked. We were disappointed to find that this situation remains largely unchanged. Although the kitchen is used more frequently for OT lead breakfast and lunch groups, it is still primarily a resource which can only be accessed by OT staff. We were told by both staff and patients that they feel the kitchen could be used more frequently if nursing staff who had completed the relevant Food Hygiene training were also able to access it for therapeutic purposes at other times of the day, for example evenings and weekends. This is a valuable and well-equipped resource which for a large part of the week is unused.

Recommendation 2:

The service should again review the arrangements for accessing the therapeutic kitchen to ensure maximum benefit of this resource for the patients.

Use of mental health and incapacity legislation

At the time of our visit eight patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') on compulsory treatment orders and four were receiving care and treatment on an informal basis. Most of the patients had been involved with mental health services for a number of years so were clear about their legal status and aware of their rights in relation to their detention. We were pleased to see that Section 47 certificates and treatment plans under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') were in place, where required. Thirteen patients had their funds managed under Part 4 of the AWI Act. and there were detailed spending plans for their funds.

Part 16 (S235-248) of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. The certificates which authorise treatment (T3) were all present, however there were some omissions where regular medication was being given without the legal authority to do so.

Recommendation 3:

Managers should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.

The physical environment

The ward is clean, bright and well maintained. The large and small sitting rooms are comfortable and well furnished. There were pictures and art work on the walls, a large activity room, and a therapeutic kitchen.

There are six single rooms with shower and toilet facilities nearby. The two four-bedded dormitory areas are relatively spacious, having originally had six beds in each and have shared shower and toilet facilities. When we previously visited we recommended that patients be encouraged to personalise their sleeping areas and bedrooms. We were pleased to see that this has been attended to and some of the bedrooms and dormitories look much more personalised and homely.

This said, many wards across NHSGGC have been refurbished to provide patients with individual rooms and we would strongly encourage managers to consider the same here to ensure privacy and to protect dignity, especially given the fact that many of this particular group of patients can be in hospital for fairly lengthy periods of time. This view was echoed by some of the patients we spoke with, with some of them being reluctant to have photographs or other personal effects on display for fear of another patient wandering past and lifting them, whereas others we spoke to did not appear to mind sleeping in a dormitory and quite liked the company.

There was a garden area to the front of the ward and a well maintained medium-sized garden to the rear. We were told that this area is well used by patients and there is a gardening group who tend to it. We also noted that the physiotherapist holds exercise groups there, weather permitting. There were bird feeders and we were told that many of the patients experience a great deal of joy watching the birds feed in the garden.

Recommendation 4:

Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

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 an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

2. The service should again review the arrangements for accessing the therapeutic kitchen to ensure maximum benefit of this resource for the patients.

3. Managers should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.

4. Managers should plan to provide single room accommodation to ensure maximum benefit to patients.

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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