Mental Welfare Commission for Scotland

Report on announced visit to: Leverndale Hospital, Ward 4A, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 5 May 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 4A is an adult acute mental health admission ward and covers the geographical area of Eastwood, Barrhead (East Renfrewshire) and Castlemilk (Glasgow City). The ward has 24 beds and is divided into two in-patient areas which have single rooms with en-suite facilities. On the day of our visit the ward was at capacity. This ward was purpose built around 10 years ago. The ward takes a mix of female and male patients; this arrangement allows for areas to be used flexibly to accommodate changing patient numbers of males and females. Seventeen patients were either on short term detention certificates or compulsory treatment orders; there were seven patients who were informal. On the day of our visit there were five patients boarding in 4A from other wards and five patients were on enhanced observations.

We last visited this service on 20 January 2020 and made three recommendations at that time. The previous visit was in conjunction with visits on consecutive days to Ward 3A and Ward 4B. The report reflected findings from all three wards but this visit will reflect findings in Ward 4A only.

We wanted to follow up on the previous recommendations and also hear how patients and staff have managed throughout the current pandemic. As at the time of our last visit, we wanted to find out if there had been progress made towards improving care planning documentation, risk assessments and MDT recording and reviewing medication records for patients authorising treatment under the Mental Health Act. This is because we are aware that the pandemic has had a significant impact on activity provision and visiting.

Who we met with

We met with and reviewed the care and treatment of eight patients and spoke with one carer by telephone the day after the visit. We spoke with the senior charge nurse (SCN) prior to the visit and again on the day.

Commission visitors

Anne Craig, social work officer

Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support and participation

Patients spoke well of the staff team. One patient commented that the nurses were "engaging and positive", another patient gave a scenario where a nurse went out of her way to provide much needed support to her overnight. A further comment was that staff were "fantastic, despite being short staffed" and the domestic and catering staff were "amazing".

The SCN spoke highly of the core staff team, although felt that the staff team were suffering from "compassion fatigue", especially as it is usual for them to have a high number of patients on enhanced observations and also patients boarding from other wards. The term "compassion fatigue" was the SCN explaining that the organisation recognised that staff had worked hard, receptive to quick changes in respond to the pandemic however now staff were tired given the duration of the pandemic.

The SCN said that there were a number bank/agency staff on the ward, but felt it was a supportive staff team and it did not compromise the care given. We heard that staffing could be a challenge but the team worked well together. The ward has a patient activity co-ordinator (PAC); we heard from those that we spoke with that there was no PAC provision at the weekends and this had an impact on social activities. However, we were pleased to hear that that having a PAC has been a significant benefit to patients during the lockdown periods, when the campus recreational therapy area has been closed.

We were made aware of patients who were vegan, required halal food and/or had special requirements. Patients spoke of the limited food menu available which for those with vegan diets, consisted of four set meals on rotation, each week.

Recommendation 1:
Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.

Two patients spoke of their religious beliefs being overlooked. In particular the celebration of Easter. It was reported that no chaplain, minister or priest visited during this religious event. Chaplaincy services are onsite, which meets the spiritual needs for all patients, they have been introduced to the patients and staff are aware of how to access these services. There is a poster in the ward offering this service. The chaplain service prior to the covid restrictions held an Easter service within the RT department. Given that we are unable to cohort wards together this was not possible.

Recommendation 2:
Managers should ensure that during religious festivals there is specific provision for patients to observe and have access to services that support their cultural needs.

Nursing care plans

The care plans we reviewed were not of a standard that reflected the service delivery and not as person-centred as we would have expected. We noted that all patients had numerous care plans in place, which appeared to be updated whether there was a change or not. The last visit made a recommendation about care plans and this visit found that little had changed. We also felt that the care plans were of a generic nature and did not identify the individual needs of each patient.

Recommendation 3:
Managers should 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/node/1203

Risk assessments were also out of date and they were not reviewed. It is critical that risk assessments are updated when any risk is identified and can be easily accessible.

We are told that risk assessments are reviewed in line with NHSGGC Policy. Attached current policy for referencing.

Recommendation 4:
Managers should ensure that risk assessment documentation is updated accordingly and accessible to all staff.

Multidisciplinary team (MDT)

The ward is served by four consultants, each covering a geographical area, although sometimes the consultant only covers out-patient or in-patient work.

There are three formal MDT's per week and consultants visit the ward and their patients throughout the week out with MDT meetings. MDT meetings are attended by medical and nursing staff, pharmacy, occupational therapy, physiotherapy and psychology when required. The SCN commented on those patients who are boarding from another ward; these patients do not get the same input from their MDT as they would if they were in their own ward.

The ward has an allocated liaison social worker who acts as the first point of contact for referrals and attends MDT meetings via Teams, this social worker only covers patients who live in the Glasgow area, but the ward has patients from East Renfrewshire. Contact with East Renfrewshire HSCP is more challenging, especially in relation to discharge arrangements.

Recommendation 5:
Managers should work with health and social care partnerships to ensure timely discharge for patients.

Relatives are not currently invited to attend MDT reviews due to Covid guidance, however they are contacted by the medical staff to discuss their views prior to the review. They are also contacted by named nurses post review with updates from the MDT and provide information on decisions taken and agreed actions. MDT reviews are recorded within the EMIS electronic

recording system although this took some time to find and the MDT template is abridged and found under "progress notes". There was a full MDT minute for each patient recorded on EMIS.

Input from other allied health professionals and specialist teams is available when required on a referral basis and there was no reported difficulty with access. 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.

Care records

Chronological notes evidenced regular one-to-one discussions between the patient and nursing staff. It was clear that the patients' views on their care and treatment were sought and this was recorded in the care plans. We were told that advocacy services can become involved with those patients who require it. Information was displayed on the ward notice board. We also witnessed the staff interacting with patients; there was a warmth and care evident in their contact.

Patients commented on the number of bank and/or agency staff who, at times are on shift, caring for the patients on the ward. There were no concerns noted and this was accepted as a need to ensure safe staffing levels on the ward. This situation is currently faced across NHS health boards at this time and is as a result of staff absence and recruitment issues.

Use of mental health and incapacity legislation

Recording of patient status in EMIS was clear and concise. The patient status was available from the nurses' station when staff receive handover. There were no concerns noted in detention paperwork or its availability.

Part 16 (S235-248) of the Mental Health Act (Care and Treatment) (Scotland) Act 2003 ('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. We reviewed the medication prescription forms and the T2 and T3 certificates. T2 certificates are completed when a patient has capacity and can consent to treatment, T3 certificates are completed when a patient is unable to consent to treatment. Where T3s were required, these were all in place however, there were a number of patients who were prescribed medications that were not covered by their current T3 and this required review. This was brought to the attention of the SCN on the day of our visit.

One patient had a section 47 certificate in place which was indefinite. Section 47 certificates authorise medical treatment for physical conditions where patients do not have capacity to consent. The Commission guidance indicates that s47 certificates should be reviewed after a period no longer than three years. We raised this with the senior charge nurse and she will contact RMO for it to be corrected. We will follow this up after the visit.

Recommendation 6:

Managers should ensure medication records are reviewed for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act and ensure s47 certificates are completed appropriately.

Rights and restrictions

The ward door is locked and entry is via a buzzer or key fob system. There is a locked door policy and information on this is provided to families and other visitors.

Although restrictions due to Covid19 are reducing, we note that visiting is still an issue. During the pandemic Ward 4A had 45 min booked appointments throughout the course of the day. Visiting in line with NHSGGC guidance. Core briefs identified that there were restrictions on visits 8 April, 29 April (some restrictions removed) and 3 May. Staff also worked hard to ensure that patients and their loved ones communicated throughout their stay. Whether it be via FaceTime on the iPad, access to a phone in private. Covid ward closures impacted on visiting arrangements where essential visits only were advised by the infection control team. Visits take place in the interview rooms or in the patient's room, if requested and appropriate. Staff advised us that they do not rigidly adhere to 45 minutes and can be flexible, if there is no detriment to the patient or the running of the ward. Patients and their visitors can go into the grounds, depending on their ability and status to do so. Visits continue to have to be pre-booked and are time limited.

Recommendation 7:
Managers should ensure that visiting arrangements are in line with current Scottish Government guidance.

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.

At the time of our visit, there were no patients who required restrictions under sections 281 to 286 of the MHA, which provides a framework in which restrictions can be placed on people who are detained in hospital.

Activity and occupation

The ward benefits from a patient activity co-ordinator (PAC), there is an activity room and a programme of activities are available for patients during the day. There is an adjacent garden area where patients can spend time. This is also the smoking area and may prevent some patients from using the outdoor space if they do not like to be in the vicinity of a smoking area. However, no patients actually highlighted this as an issue. This area is an enclosed space with fencing for privacy and safety, as it runs alongside the River Cart. Whilst there was no PAC nurse at the weekends, the SCN explained that nursing staff facilitate groups at the evenings and weekends. At events such as Halloween and Easter, the staff will facilitate a themed weekend for these (there are photographs of these activities). The Health Care Support Worker group has a core team who focus on activities such as pamper days, football days/nights, bingo, and arts and crafts as some examples.

Therapies staff ensured that there was also activity packs for patient who were required to self-isolate for infection control covid screening. These resources were also utilised outwith requirements for self-isolation.

We were pleased to hear that the recreational therapy area is about to re-open to patients from across the site. We were advised that there is a planned programme for each ward to have allocated days or sessions. Following each activity, there will be a deep clean undertaken. During the pandemic, staff had taken an in-reach approach to the patients in their own wards. The recreational therapy staff team's ethos is to have no barriers to engaging with recreational activity and for therapy to promote good mental wellbeing and health. It is intended that some in-reach will continue to the wards and will complement the main recreational therapy area and activities in their own building. The re-opening of the recreational therapy area will complement the work undertaken by the PAC, who is based on the ward.

We spoke with occupational therapy (OT) staff who outlined that group work had been reduced due to the demands on the service/Covid-19. OT staff primarily focus on community access and preparing patients for safe discharge as well as signposting to the appropriate services. The OT staff contribute to the MDT process which helps provide overview of patients getting ready for discharge; the current nursing manager has been supportive of this service need. The only negative highlighted by the OT staff member was the need for more dedicated OT time for patients.

Recommendation 8:
Managers should ensure that patients have access to meaningful activity and occupation seven days per week.

Recommendation 9:
Managers should ensure that when a patient accepts or declines the activities that are offered, this is noted in the patient's file.

The physical environment

The ward shares a communal entry area with ward 4B. This building is purpose-built and both wards are a mirror image of each other. We particularly liked the design of these wards, where the nurses' station was at the centre of the ward, where all corridors can be seen from the central area; this offers an opportunity for informal patient observation and early intervention if required. One patient commented that room 24 was not visible from the nurses' station. We noted that there were staff in the communal area who could observe this room.

The ward is light, bright and spacious. We particularly liked that there were some larger rooms that could accommodate assisted patients. During our visit there were several patients who were watching television, a few staff were sitting with the patients enjoying general conversation and providing support as needed. There were accessible quiet rooms and also at the end of each corridor, a small couch where patients could sit and enjoy the garden area or have some personal time away from the main hub of the ward. The ward was spotlessly clean, as were the patients' rooms that we saw. A few of the patients had personalised their rooms but it is unlikely that all patients would do this, due to the ward being an acute admissions ward, with the expectations that patients will move on as soon as they are able to do so.

Summary of recommendations

1. Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.

2. Managers should ensure that during religious festivals there is specific provision for patients to observe and have access to services that support their cultural needs.

3. Managers should ensure that care plans address the specific needs of individual patients.

4. Managers should ensure that risk assessment documentation is updated accordingly and accessible to all staff.

5. Managers should work with health and social care partnerships to ensure timely discharge for patients.

6. Managers should ensure medication records are reviewed for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act and ensuring s47 certificates are completed appropriately.

7. Managers should ensure that visiting arrangements are in line with current Scottish Government guidance.

8. Managers should ensure that patients have access to meaningful activity and occupation seven days per week.

9. Managers should ensure that when a patient accepts or declines activities that are offered, this is noted in the patient's file.

Service response to recommendations

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

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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