Mental Welfare Commission for Scotland

Report on announced visit to: Leverndale Hospital, Ward 4B, 510 Crookston Rd, 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 4B is an adult acute mental health admission ward and covers the geographical area of Govan and Ibrox (Glasgow City) and Cambuslang and Rutherglen (South Lanarkshire). The ward has 24 beds and is divided into two inpatient areas which have single rooms with en-suite facilities. This ward was purpose built around 10 years ago. The patient profile is predominantly for first presentation psychosis and many are younger males. The ward takes a mix of female and male patients. 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. All patients were either on short term detention certificates or compulsory treatment orders.

On the day of our visit there were 23 patients in the ward, one room was not in use due to a broken window. Two patients were on enhanced observations.

On this visit we wanted to look at care plans, activity provision and visiting arrangements. This is because we are aware that the pandemic has had a significant impact on activity provision and visiting. We were assisted to view patient records on EMIS web, the electronic recording tool used in the ward.

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 4A. The report reflected findings from all three wards but this visit will reflect findings in Ward 4B only.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the current pandemic. We also wanted to find out if there had been progress made towards improving care planning documentation, risk assessments and multidisciplinary team (MDT) recording and reviewing medication records for patients authorising treatment under the Mental Health Act.

Who we met with

We met with and reviewed the care and treatment of five patients and spoke with one carer. We spoke with the senior charge nurse (SCN) prior to and on the day of our visit.

Commission visitors

Anne Craig, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

Without exception all patients we spoke to had only praise for the staff team. One patient who had been in the ward for only a short time described the staff team as “looking out for me”, and that staff support was “minted”. Staff were described as “brand new, available and very approachable”. We heard “nurses are amazing, they listen, treat me with respect and the doctors are good, I’m invited and included in MDT’s and I feel listened to”.

The SCN spoke highly of the core staff team. We heard that there has been a number of inexperienced staff on the ward but the SCN felt it was a supportive staff team and it did not compromise the care given. The SCN advised that staffing could be a challenge but the team worked well together. The ward has a patient activity co-ordinator (PAC) whom we met whilst on the visit and, we were able to access the activity room on the ward. This is noted to have been of benefit to the patients during the lock-down periods, where the campus recreational therapy area had been closed.

One patient had phoned the Mental Welfare Commission during Ramadan as he was observing his faith and could only eat and drink during the hours of darkness. We had advised the SCN of this call to our advice line and followed this up on our visit. The patient advised us that this had not been resolved.

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 were four set meals, on rotation, each week.

Two patients spoke of their religious beliefs being overlooked, specifically in relation to the celebration of Easter. It was reported that there had been no chaplain, minister or priest that visited during this religious event.

Recommendation 1:
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.

Recommendation 2:
Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.

Patients commented on the number of bank/agency staff who, at times, are on shift, caring for the patients on the ward. No concerns was noted and this was accepted because of the need to ensure safe staffing levels on the ward. We heard from the SCN that bank/agency staff are mainly used for night shifts. This is due to the situation faced across NHS health boards at this time and is as a result of staff absence and recruitment issues.

Nursing care plans

The care plans we reviewed were not of a standard to reflect 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 in relation to content. We also felt that the care plans were of a generic nature and did not identify the individual needs of each patient. None of the patients we spoke with had seen or recalled discussing a care plan. There was evidence of one-to-ones, where care and treatment was discussed but we would expect patients to be involved in care planning and be provided with a copy of their care plan.

Recommendation 3:

Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards their stated care goals and where a recording of reviews is consistent across all care plans.

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

Multidisciplinary team (MDT)

The ward is served by five consultants, each covering a geographical area, although sometimes the consultant only covers in-patient or out-patient work. One of the consultants also has responsibility for Esteem, a mental health service for people aged 16-35 who appear to be experiencing a first episode of psychosis and requiring in-patient care. Esteem offers different types of support which have been shown to help people recover from psychosis, including medication, practical support, family work and psychological therapy.

There is one formal MDT per week, although out with this, consultants visit the ward and meet their patients throughout the week. MDT meetings are attended by medical and nursing staff, pharmacy, occupational therapy (OT), physiotherapy and psychology when required. 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, however, the ward has patients from South Lanarkshire. Contact with South Lanarkshire HSCP is more challenging.

Recommendation 4:

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-19 guidance, however they are contacted by the medical staff to discuss their views prior to the review. They are also contacted by the named nurse post-review with updates from the MDT and they provide information on decisions taken and agreed actions. MDT reviews are recorded in the EMIS electronic recording system although this took some time to find and the MDT template is

abridged and found under “progress notes”. While the abridged version was useful, a full MDT template for each patient should be recorded in the patient’s notes.

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 OT, physiotherapy and pharmacy.

Recommendation 5:
Managers should ensure that risk assessment and MDT recording is robust and available to all staff as required.

Care records/nursing notes

Information on patients care and treatment is held in three ways. There is a paper file, the electronic record system EMIS and information is also stored on the s-drive of the electronic system. We found this cumbersome to navigate. There was no indication of where specific pieces of information were located. We were concerned that this could lead to a risk of information going missing. We discussed this on the day of the visit and were advised that discussions are ongoing with the IT department to ensure that future plans are for most information to be saved in the EMIS system. As an interim measure, we suggested having a list in the paper files, detailing where specific information can be located.

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; this was recorded in the care plans. We were told that advocacy services can be involved with those patients who require it. We also witnessed the staff interacting warmly with patients, and observed there to be care evident in their contact.

Use of mental health and incapacity legislation

Recording of patient status in EMIS was clear and concise. The patient’s 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 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. There were no issues with the medication paperwork. We did not identify any patients who should have had a completed section 47 certificate. Section 47 certificates authorise medical treatment for physical conditions where patients do not have capacity to consent.

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 Covid-19 are reducing, we noted that visiting is still an issue. The ward provides visiting

for 45 minutes on one session per day, in the evening. Although the ward accommodates visits out with this time, if requested, and if the visit does not impact on the functioning of the ward. Visits take place in the interview rooms or in the patient's room, if requested and appropriate. 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 6:
Managers should ensure that visiting arrangements are in line with current Scottish Government guidance.

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.

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

The ward benefits from a patient activity co-ordinator (PAC), there is an activity room and a programme of activity is available for patients during the day. There is an adjacent garden area where patients can spend time which is shared with Ward 4A. This is also the smoking area for both areas and may prevent some patients from using the outdoor space if they do not like to be in the vicinity of a smoking area. No patients highlighted this as an issue on the day of the visit. The area is an enclosed space with fencing for privacy.

All patients spoke positively about the range of activities available to them; options included football classes, gym and cooking/baking (with OT) and we noted there were activity planners in some of the bedrooms.

We had previously spoken with the acting charge nurse (CN) for the recreational therapy area which was just about to re-open to patients from across the site. The CN advised us that there each ward will be allocated days or sessions, and after each activity session, a deep clean is undertaken. During the pandemic, staff had taken an in-reach approach to the patients in their own wards. We were impressed with the range of skills and abilities in the recreational therapy staff team and in their ethos to have no barriers to engaging with recreational activity and therapy, in order to promote good mental wellbeing and health. It is intended that some in-reach will continue to the wards. Although 4B has a PAC, the re-opening of the recreational therapy area will complement the work undertaken by the PAC on the ward.

Recommendation 7:

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

Recommendation 8:

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

The physical environment

The Ward shares a communal entry area with Ward 4A. 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, and where all corridors could be seen from the central area. This offered an opportunity for informal patient observation and early intervention if required. The ward is light, bright and spacious. We particularly liked that there were some larger rooms which could accommodate assisted patients.

During our visit there were several patients who were watching morning television, there were a few staff sitting with the patients enjoying general conversation and providing support as needed. There were quiet rooms which could be accessed and also at the end of each corridor, a couch was available, where patients could sit and enjoy the garden area or have some personal time away from the hub of the ward. The ward was spotlessly clean, as were the patients' rooms that we observed. A few of the patients had personalised their rooms but this is likely due to the ward being an acute admissions ward, there is an expectation that patients will move on from this ward as soon as they are able to do so.

There were two fish tanks on the ward and staff encourage the patients to look after the fish and the tanks.

Summary of recommendations

1. 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.

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

3. Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards their stated care goals and where a recording of reviews is consistent across all care plans.

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

5. Managers should ensure that risk assessment and MDT recording is robust and available to all staff as required.

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

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

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

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.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk