Mental Welfare Commission for Scotland

Report on announced visit to: Leverndale Hospital, IPCU, 510 Crookston Rd, Glasgow G53 7TU

Date of visit: 16 June 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.

The Intensive Psychiatric Care Unit (IPCU) at Leverndale Hospital is a 12-bedded unit for patients aged 18-65 years requiring intensive treatment and intervention, and patients are generally from the south Glasgow area. The function, layout of the ward, and facilities are unchanged since our previous visit.

The ward is a mixed-sex facility, split as maximum of three female single bedrooms and nine to 12 male beds in a mix of single rooms and small dormitory accommodation. On the day of our visit all twelve beds were occupied. There were three female and nine male patients.

We last visited this service on 22 June 2021; we made recommendations regarding the need to address the provision of psychology to the ward, and the length of stay for patients in the IPCU.

On the day of this visit we wanted to follow up on these recommendations and have the opportunity to speak to patients about their care; particularly their experiences during the Covid-19 pandemic.

Who we met with

We met with and reviewed the care and treatment of seven patients and spoke with four relatives.

We met with inpatient service manager for the ward, as well as the nurse in charge and other nurses on the ward

Commission visitors

Justin McNicholl, social work officer

Lesley Paterson, senior manager (practitioners) east team

What people told us and what we found

Care, treatment, support and participation

As our visit was announced, patients, relatives, and staff were prepared for our visit and we were given full access to the ward to meet with patients and staff. During the visit we met with four family members who were generally complimentary about the nursing care provided in the ward. They advised us that they found nursing staff to be approachable and welcoming of their involvement in their family member's care, and that the overall care provided was of a high standard.

The ward has input from one consultant psychiatrist, one doctor with a specific remit for the ward and one junior doctor. We heard from nursing staff that access to medical staff is good and that there is a high ratio of staff to patients; this is particularly important in an IPCU ward where there are increased levels of clinical risk and patient needs are high. There were two patients on one=to-one observations at the time of our visit. Due to the level of observations in place and vacancies, the ward is having to employ bank and agency staff to ensure staff cover for the ward. A concern of this, is that this has led to a reduction in experienced staff.

We were informed that following on from a significant adverse event review, the management structure of the ward has changed since our last visit. This includes a new senior charge nurse (SCN) for the ward, as well as the plan to have three charge nurses working in the ward to support staff and patients. The increase in staffing aims to ensure consistent supervision, recording and reporting. We were advised that to improve patient care the introduction of additional time at the shift handovers of staff has helped to improve communication. The feedback from staff is that this has been a positive change. On the day of our visit, despite a full complement of health care support workers for the ward, there were two agency staff in place assisting with one-to-one observations.

We also heard that due to the significant adverse review, steps had been taken to ensure that all prescribed medication, whether it is in oral form or intramuscular (IM) injection would be recorded appropriately in the patient's medication record, whilst adhering to the local prescribing policies for NHS Great Glasgow and Clyde(NHS G,G & C). Unfortunately, we found that the route of administration was rarely documented on the medication record; this lack of consistent practice continues to raise concerns regarding the prescribing and recording of psychotropic medication.

Recommendation 1:
Managers must ensure the prescribing of 'as required' medications is in line with NHSGGC policy and best practice guidelines to ensure dosages, routes of administration and maximum daily dose are clear.

It was positive to note that psychology input to the ward has been prioritised since our last visit recommendation. However, the feedback from some family members indicated that swift access to counselling, trauma informed therapy and psychology input for those in the ward should be more accessible, especially when patients have requested this treatment.

Of the twelve patients on the ward at the time of our visit, nine had been in the ward for less than three months so most patients are spending relatively short periods of time on the ward as we would expect. We were concerned that there were two patients in the IPCU who have now been on the ward in excess of two years. Though there are plans for these patients (one is awaiting assessment for a forensic bed and another on community placement) transfers need to be prioritised by all parties. The Commission had previously raised concerns regarding the length of stay for some patients in the IPCU; this situation is still of concern. We consider that the ongoing long-term placement of patients in the IPCU ward, due to lack of bed availability in more suitable services or community placements, is not in-keeping with good patient care and treatment. One patient whom we met with, and who is on the delayed discharge list having been in the ward for over three and half years, and who has no identified discharged date stated, "I feel tired of waiting, I might die here". This situation continues to be a significant concern and we continue to escalate those who are delayed with their discharge from the ward with the Responsible Medical Officer (RMO) senior managers in the health board and the appropriate Health and Social Care Partnership for immediate action. The Commission will follow up on the progress towards discharge of these patients.

Generally there was positive feedback from the patients we met regarding their care. Patients seemed comfortable in the company of staff and happy to approach them. We saw staff engaging with patients and all the interactions we observed were warm, friendly and respectful. Patients all have an individual care plan. These are personalised but we noted that for many patients the IPCU, the ward's focus appears to be primarily on containment rather than therapeutic intervention. Some of the nursing care plans of the patients we reviewed were person-centred and recovery-focussed however, many of these care plans did not include a signature from the patients or member of staff to acknowledgment a patient was either unable or had refused to sign.

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

Recommendation 2:

Managers should ensure there is patient involvement and participation in care planning and that this is evidenced in each care plan.

The majority of patient records are recorded on the EMIS electronic records system. The risk assessments we read were detailed, regularly reviewed, and we saw individual risk management plans included in the patients' records. There was clear evidence of weekly multidisciplinary team (MDT) meetings and regular reviews of care, including input from pharmacy. Despite this we heard from patient's family members and named person that they were not routinely invited to planned MDT's and they did not feel they were communicated with by the Responsible Medical Officer regarding their relative's care. We found many of the MDT forms repeatedly expressed the same view from the patient. The Commission recommends a review of this process to ensure that patients and their families or named

person are included and their views are recorded, including a record of the patients' preferences not to provide a view. A consistent approach by all staff is required to ensure that all patients have the opportunity to express their views and that this is recorded fully throughout their time in the ward.

Recommendation 3:

Managers should ensure regular participation and engagement with the patient, their families and named person at multidisciplinary team meetings.

We heard from all patients and staff that advocacy input to the ward was easily accessible, responsive and the patients find it helpful.

Use of mental health and incapacity legislation

On the day of our visit, all twelve of the patients in the IPCU were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 (CPSA). Most of the orders in place were under the Mental Health Act. The appropriate detention paperwork was readily available.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health were not always in place, meaning there were instances where psychotropic medications was being administered without the legal authority to do so.

Recommendation 4:

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

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. One patient had a section 47 certificate in place and was also subject to Part 4 of the AWIA. In relation to the patients' welfare benefits, the NHS has applied to the department of work and pensions (DWP) to have an appointeeship role to manage patient's welfare benefits; we found that the paperwork relating to this safeguard was in place.

Rights and restrictions

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. We found no evidence of any advanced statements for any patients in the IPCU. In speaking with staff, there was no apparent promotion of advanced statements in the ward. 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 5:

Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinical notes and care plan

The IPCU operates a locked door policy commensurate with the levels of vulnerability and risk of the patient group. There were individual detailed risk assessments in place for patients which set out the arrangements for time off the ward and what support was required to facilitate this safely. On the day of our visit there were two patients who were on one-to-one observations. We noted that for some of the patients who were subject to observation, these had been in place for prolonged periods of time. Improving Observation Practice guidance recommends that this high level of intervention should be reviewed after 24 hours to assess its effectiveness. In the patient records there was limited evidence of these review processes being conducted, although we heard from staff that enhanced observations were reviewed regularly.

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/rights-in-mind/

Recommendation 6:

Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

Activity and occupation

Activities for patients in IPCU wards are important due to the level of restrictions they face. We were pleased to hear of the therapeutic activity nurse employed to work flexibility with patients out with the routine 9am-5pm timetable. This ensures that there is an offer of support and activities for all patients. During our visit we were able to observe a full list of daily activities in the ward. We were advised of the consistent support supplied to the ward by occupational therapy, physiotherapy and dietitian staff who provide group work and one-to-one sessions to patients. Prior to the Covid-19 pandemic, patients had previously benefitted from being able to access the recreational therapy (RT) unit with in the hospital. This building had been closed due to the pandemic, but has now reopened and will further enhance opportunities for patients in the IPCU. Recreational therapy workers have been providing additional activity input to the ward while the unit was closed.

We heard a number of comments from patients regard the lack of access to a television on the ward. The previous television had been damaged by a patient three weeks prior to our visit and had not yet been replaced by the management. This matter should be addressed imminently as it remains an important for patients in a restricted environment.

The physical environment

During our visit we were informed that work was being undertaken to update the appearance of the building. This was positive to note as the ward presents as a stark, with the environment showing signs of age, with general wear and tear apparent throughout all aspects of the ward. The basic decor of the ward does not provide for a positive experience for patients, with some requiring to sleep in dorms with fellow patients. Patients told us that the noise and condition of the ward are far from ideal for maximising patient care.

Although we heard that there are no plans to change the physical make-up of the building or the lay out of the ward in the foreseeable future, we hope that the current update will be an improvement and we look forward to visiting the ward in future to observe the planned improvements.

Any other comments

Due to the recent death of a patient detained in the IPCU, we spoke with the senior management and staff regarding the findings and recommendations from the significant adverse event review. The Commission have noted the recommendations made by the authors of that report and it was positive to see some initial improvements have been undertaken to address the findings of the significant adverse event review. We look forward to seeing how these develop alongside the recommendations made in this report.

Summary of recommendations

1. Managers must ensure the prescribing of 'as required' medications is in line with NHSGGC policy and best practice guidelines to ensure dosages, routes of administration and maximum daily dose are clear.

2. Managers should ensure there is patient and staff participation in care planning and that this is evidenced in the care file.

3. Managers should ensure regular participation and engagement with the patient, their families and named person at multidisciplinary team meetings.

4. Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form, where required, and a system of regular auditing compliance with this should be put in place.

5. Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinic notes and care plan.

6. Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

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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