Mental Welfare Commission for Scotland

Report on unannounced visit to:

Rehabilitation Ward, Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 3 October 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 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 in-patient 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 symptoms of their illness.

We last visited the service on the 15 December 2020. Following that visit we made three recommendations; the first was in relation to the promotion and recording of advance statements, the second was about the fabric of the ward, in particular the need for single room accommodation, and the third related to the layout of the ward for observing patients and the associated risks. The response we received from the service informed us that clear auditing was now in place to ensure adherence to advance statements. The rehabilitation service remains under review, with priority being given to single room accommodation. In relation to the layout of the ward, environmental checklists have been completed that have highlighted areas of risks which remain under review, and those areas of high risk are actioned immediately.

On the day of our visit there were 10 patients in the ward, six males and four females. We wanted to meet with patients, and their relatives, and to follow up on the previous recommendations, as well as finding out how the Covid-19 pandemic continues to impact upon patient care and treatment.

Who we met with

We met with and reviewed the care and treatment of seven patients in the ward, and spoke with one family member to hear their views.

We spoke with the service manager, the operational manager, the senior charge nurse, staff nurses and the psychiatrist who were able to provide updates on the ward.

Commission visitors

Justin McNicholl, social work officer

Douglas Seath, nursing officer

What people told us and what we found

As our visit was announced, patients, relatives, and staff were prepared for the visit and we were given full access to the ward to meet with patients and staff. The majority of patients we spoke with were satisfied with the nursing and allied health professionals' care and support. Many patients spoke positively of the staff with one stating "this is the best ward in the hospital as staff are less rushed and have time to talk and help you to work through any difficult situations".

It was clear that rehabilitation and recovery was at the heart of the care being delivered to all patients, with a wide variety of opportunities open to all. Patients described being actively involved in their treatment and rehabilitation, highlighting the development of life skills, and also a variety of activities that were tailored to their individual needs. We noted that the service also provides information and signposts patients to access local organisations. Both patients and staff discussed that the pandemic continued to have an impact on accessing activities in the local community, due to some services ceasing and never resuming.

We heard from nursing staff that that there were challenges around staffing in the ward. In particular, there were absences due to sickness levels. This has resulted in bank staff being utilised to fill shifts. Despite this, both staff and patients reported that the staff that covered these shifts were consistent and this helped to maintain a positive focus on care.

Care, treatment, support and participation

On the day of our visit, the ward was calm and notably, there was a relaxed atmosphere. We observed positive interactions between staff and patients. There is a diverse group of patients in the ward, many who have been in hospital for a considerable number of years. The nature of their illness means their ability to engage and participate in activities of daily living, therapeutic, social and recreational activities will depend on their mental wellbeing.

We saw evidence of considerable efforts made by nursing, occupational therapy (OT), and psychiatry and psychology staff to encourage engagement in each patient's treatment and activities. The level of proactive engagement and shared care planning between staff and patients appeared to be helping to manage and de-escalate any associated risks for each individual patient.

Of the patients we met, some expressed their frustration at delays in discharge into the community. Despite these apparent delays, we were able to obtain the rationale for the delays and any associated risks. There was clear evidence in the care notes with a full explanation being supplied by the lead clinicians.

During our visit we had contact with one relative; they were complimentary about the care and treatment being provided. They felt that communication and engagement with the clinical team was good. We saw on this visit that the ward is supporting a partnership approach to the provision of care and treatment, and that staff are encouraging relatives and carers to be as involved as they wish to be in the provision of care and treatment.

We reviewed the majority of care plans which had comprehensive details around the interventions used to support and help improve the patients' mental health. We found all care

plans were person-centred. They captured the complexities of the patients we met with as well as the care that was being utilised to ensure the patients' recovery.

We were pleased to see personalised risk assessment and management plans. These were accessible, again with a clear rationale set out on what support achieved the best outcomes for the patients.

Multidisciplinary team (MDT)
There was evidence of weekly MDT meetings taking place, in person or virtually, to ensure attendance was maximised. 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; they then receive post-meeting feedback. Patients spoke positively of being able to engage with the MDT process both in person and virtually, without incident.

On reviewing the MDT records there was evidence of input from medical, nursing, allied health professionals and pharmacy. Actions and outcomes were clearly recorded on MDT forms, and documentation was detailed to a high standard. There was acknowledgement that participation by carers and families at MDTs was limited. Despite this, individual meetings with carers and families are offered by the team. This ensures that the care programme approach (CPA) meetings can further ensure participation and engagement, either in person or virtually. To support families, we were pleased to hear that behavioural family therapy has been offered to patients and families since Covid-19 restrictions have eased.

There was evidence of input from psychology services to the ward, in the form of group work, with a focus on rehabilitation. We were informed of a gap since our last visit, in regards to the previous psychology assistant, who has since moved on from the ward. Due to the complexity of the presentation of some patients, the team acknowledged that patients would benefit from having this post recruited to. It was positive to hear that there are plans in place to address this gap in the service and when we next visit we look forward to hearing how the newly appointed team member has helped to improve patient care on the ward.

There is currently no dedicated GP service provided to the ward to ensure annual health checks. When we reviewed the notes today we could see no evidence of annual health checks taking place on a consistent basis. Despite this there appears to be regular monitoring of 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.

Recommendation 1:
Managers should ensure regular contact with the local general practitioners to ensure that, at a minimum, annual health checks are undertaken for each patient.

The ward has regular input from occupational therapy, dietitian and physiotherapy. Referrals are made to podiatry and speech and language therapy when required. Pharmacy staff are available for consultation, completion of medication reviews, and will spend time with patients discussing their medication when this is required.

There are currently two systems for recording documentation. EMIS, the electronic record keeping system that contains the majority of care including daily notes, chronologies and MDT documentation and paper files for care plans. The goal for the health board is for all information be accommodated on EMIS which would end the need for paper files; we look forward to reviewing when we next visit the ward.

We found the standard of care plans to be consistent in terms of personalisation. There is ongoing use of the Camberwell assessment of need (CAN) and care plans are jointly written with patients in response to the CAN. We were impressed by the combined support plans as they appear holistic, comprehensive, and involve all members of the MDT. We found them to be detailed in terms of physical health, mental health and social needs, and they ensured that the patient is held at the centre of care and treatment. The care and support plans are reviewed at the MDT meeting and audited by the senior charge nurse.

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

Of the 10 patients on the ward at the time of our visit, nine had been in the ward for at least two years; this length of stay is not unexpected in this type of service. Despite this, we consider that any long-term placement of patients in hospital should be kept under regular review, and we were pleased to see this was the case when visiting this service.

Use of mental health and incapacity legislation

On the day of our visit, all ten of the patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('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 appropriate consent forms in place for the patients that needed them.

Where an individual lacks capacity in relation to decisions about their financial affairs, we found that the paperwork relating to management of patient finances was in order. There were four patients having their affairs managed by the NHS to ensure appropriate budgeting and safeguarding is in place.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are subject to detention in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed. There were no patients on the day of our visit who were subject to these procedures and we were informed that any consideration would be discussed and reviewed weekly at the MDT to determine whether restrictions in place were required.

Our specified persons good practice guidance is available on the Commission website at: https://www.mwcscot.org.uk/node/418

Rights and restrictions

The ward has an open door policy during the day, with a locked door policy in the evening for the general safety of patients and staff. This means that patients can enter and leave the building as they wish.

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want should they become unwell again in the future. The Commission supports the use of advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. Health Boards have a responsibility for promoting advance statements. We found good evidence of advance statements being recorded and offered to all patients in the ward. This included evidence of when patients decided not to complete one but had been offered the option. In speaking with staff, there was clear promotion of advanced statements in the ward.

We were informed by patients and staff that advocacy input to the ward is very good, as is the uptake of this service.

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

On reviewing each patient file we were pleased to see occupational therapy functional assessments, reviews, comprehensive activity planners and treatment plans. There are a range of activities taking place on the ward including music, cooking groups, art and crafts groups, beauty sessions, socialising through games and weekly themed nights.

Since our last visit it is positive to note that the on-site recreational therapy (RT) department has re-opened; this has improved patients access to a range of 'off-ward' activities. There is recognition that the RT department has not yet fully returned to the pre-pandemic service it provided. Patients are currently being offered the opportunity to attend RT once per week. We heard from management that RT access will be expanding in the coming months and we look forward to hearing of the expansion of the service at our next visit.

In the absence of full access to activities, we heard of the various steps taken by staff to help patients plan their daily schedule. An example was given where patients preload supermarket cards which help when purchasing shopping, helps them to prepare meals and complete kitchen activities. These creative approaches are helping to maximise patient engagement.

During our visit we could see the activity board with the week's events displayed in the corridor. We also observed the extensive art work undertaken by patients in the ward to help

personalise the communal areas and their rooms. We heard from patients that these activities offer tailored options that meet individual preferences.

We heard from patients and staff that due to limited staffing and sickness, the opportunity to complete day-to-day recreational activities on the ward can be compromised. The need to prioritise essential delivery of patient care and treatment over the provision of therapeutic activities has been helped through the support of therapeutic activity nurses (TANs); they provide assistance in ensuring that activities are prioritised for patients each day. Due to the lack of TANs staff in the rehab ward, this option is not readily available to for this group of patients.

Recommendation 2:
Managers should undertake a review into the need for therapeutic activity nurse provision support for the ward.

The physical environment

The accommodation in the ward 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. Since our last visit, work has been undertaken to improve aspects of the ward, including access to a new family room.

During our visit staff continue to acknowledge that although the ward was adequate, it was far from ideal. It remains disappointing to note that patients who are in wards for prolonged admissions are required to share facilities which can compromise their dignity and privacy. Many wards across NHSGGC have been refurbished to provide patients with individual en-suite rooms. In line with our last visit we were told that NHSGGC continue to review the totality of rehab services, due to the variations in the ward profiles across the estates. We continue to strongly encourage managers to consider the same for the rehab ward. This view was echoed by some of the patients we spoke with, who commented that the lack of privacy, and noise from other patients, can have an impact on their experience in the ward.

During our last visit we heard of 'hidden areas' where observation by staff is difficult and various ligature points were a concern, due to the dated fixtures and fittings. We heard that a site review has been completed since our last visit, to look at the risk of self-harm, acts of suicide or attempted suicide in the mental health in-patient facilities across NHSGGC. Despite this, there remains an ongoing acknowledgement that the ward remains unconducive to a rehabilitation environment.

Recommendation 3:
Managers should ensure that the ward environment is upgraded to create a conducive setting for rehabilitation and that consideration be given to single room accommodation.

However, the ward does 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. 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, who enjoy being able to access the outdoor space for activities, including maintaining the flower beds, planting seeds and tending to plants.

Summary of recommendations

Recommendation 1:
Managers should ensure regular contact with the local general practitioners to ensure that, at a minimum, annual health checks are undertaken for each patient.

Recommendation 2:
Managers should undertake a review into the need for therapeutic activity nurse provision support for the ward.

Recommendation 3:
Managers should ensure that the ward environment is upgraded to create a conducive setting for rehabilitation and that consideration be given to single room accommodation.

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.

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