Mental Welfare Commission for Scotland

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

Date of visit: 18 January 2023

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 to 65 years, who requiring intensive treatment and intervention; patients are generally from the South Glasgow area. The function, layout of the ward, and facilities are unchanged since our previous visit. The ward continues to be a mixed-sex facility, split as maximum of three female (single rooms) beds and 9-12 twelve male beds in a mix of single rooms and small dormitory accommodation. On the day of our visit all twelve beds were occupied by male patients.

We last visited this service on 16 June 2022; we made recommendations regarding the prescribing of as required medications and the authorisation for prescribed psychotropic medication. We also recommended that there should be patient and staff participation in care planning, participation at multidisciplinary team meetings by patients, their families and named persons, as well as training for staff to address the uptake of advance statements and that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

The Commission had planned to visit the IPCU in June 2023 to follow up on these recommendations and to hear from patients, carers and staff. This visit was to be announced and the service would have had been notified in advance. However, further to the Commission being advised of two significant adverse events that occurred under similar circumstances, this unannounced visit was planned to review the care of patients while a parallel significant adverse event review (SAER) has been undertaken by NHS Greater Glasgow and Clyde.

For this visit, we wanted to meet with as many patients on the ward as possible to hear about their experiences and any concerns they had about their care and treatment.

Who we met with

We met with and reviewed the care of eight patients, whom we met with in person and reviewed their care records. We also met with two relatives and had the opportunity to hear their views about the IPCU.

We spoke with the service manager, the senior charge nurse, and nursing staff throughout the day of the visit.

Commission visitors

Justin McNicholl, social work officer

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

Care, treatment, support and participation

As this visit was unannounced, patients, relatives, and staff were not prepared to meet with the visiting officers. Despite this, we were given full access to the ward to meet with patients and staff.

Patients expressed mixed views on their experiences. Some patients were generally complimentary about the nursing care provided in the ward, describing the staff as “kind”, “caring” and “approachable”. However some patients indicated that they were “not being understood by the doctor” and felt like they had “no rights, I get treated like a child”. Most patients expressed the view that their nearest relative or named person was given regular access to the care team and that they were able to ask open questions about future care planning.

We were pleased to see and hear from patients, and their relatives, that where a patient’s first language was not English, there were recorded meetings with interpreters held about their care and treatment. The ease of access to interpreting services for patients and their relatives was positive to note. We continue to promote the importance of using technology/devices to support patients whose first language is not English.

We heard that recruitment and retention of nursing staff was a concern, with the ward having to rely on agency and bank staff. There were a number of regular bank staff that worked on the ward but this did not replace having a core team who would know their patients well, had good links with the wider multi-disciplinary team and were able to support carers and relatives.

A number of patients raised issues regarding the use of agency staff on the ward, who were required due to the level of observations for the most unwell patients. Patients told us that they felt that they could not always approach these members of staff to have “frank and honest conversations” as there was a view that the agency staff lacked empathy, had poor communication skills and were only visiting for short periods of time. Staff whom we met with reported that agency staff would on occasion fall asleep whilst undertaking direct observations and this increased the risk of adverse events occurring for patients. We did not witness any of these incidents during our visit, however we would recommend that managers monitor and review the use of agency staff in the ward to ensure that no risks are posed to patients as a result of this workforce deployment strategy.

Recommendation 1:
Managers should review the suitability of all agency staff deployed to the ward and whether all agency staff are meeting the requirements to provide safe care.

The IPCU can be a busy ward that regularly has many restricted patients. Due to the restrictions and how unwell some patients can be it was described as a “pressure cooker” by members of staff. Some patients spoke positively about having ease of access to activities to keep them occupied on the ward to avoid the busy atmosphere, which included pool, television and a games console.

The ward has input from one consultant psychiatrist, one doctor with a specific remit for this ward and one junior doctor. We heard from nursing staff that access to medical staff remains unchanged since the last visit and that there is a high ratio of staff to patients; this remains important in an IPCU ward where there are increased levels of clinical risk and patient needs are high.

There were three patients on one-to-one observations at the time of our visit. With this number of patients on observations, combined with a number of staff vacancies in the ward, the use of bank and agency staff was higher than usual on the day of our visit. This has brought ongoing challenges, including a reduction in experienced and consistent staff. We were able to access their observation sheets during our visit; these were up-to-date and consistent with recording standards. Managers informed us that staff have received training from the practice development nurse (PDN) on enhanced observations which had outlined their roles and responsibilities. The PDN has provided one-to-one sessions for registered nursing staff on the standards expected in relation to record keeping and care planning. Pharmacy had also arranged training for staff on the safe management of acutely disturbed patients. We look forward to visiting the ward in the future to see how this training has ensured safe care for patients in the IPCU.

During our last visit in June 2022, we were informed that following a SAER, the management structure of the ward had changed, and an action plan was put in place to address the concerns found by the review. The changes resulting from the plan initially appeared to have ensured a consistent message to staff surrounding the use of observations, appropriate care standards and the administration of as required medication. Despite this, there was a further adverse event in September 2022. On this visit we examined the various steps taken by the service in response to the action plan; we wanted to review if the action plan in place was reflective of the experiences of patients and staff. This involved meeting with patients and staff to identify whether the actions in the action plan were influencing practice and the experiences of patients. We were pleased to note that regular supervision and support was readily available for all staff on the ward. Staff reported feeling supported by the senior charge nurse and deputy charge nurse.

We heard that significant steps had been taken to ensure that all prescribed medication, whether it was in oral or via intramuscular (IM) injection form would be recorded appropriately in patients' medicine prescription sheet, whilst adhering to the local prescribing procedures for NHS Great Glasgow and Clyde. Unfortunately we found evidence during our visit that patients' drug allergies were not appropriately recorded on file. We further discovered that the frequency of the use of as required medication was not specified for certain patients. This lack of consistent practice highlighted concerns regarding the recording of patients' medication that potentially places patients at risk of harm by those tasked to safely manage their care. As a result of this finding, we are reiterating our previous recommendation to the service made in June 2022.

Recommendation 2:
Managers should ensure prescriptions of 'as required' medication are recorded as specific dosages with frequency of administration and daily maximum dose made clear. This is necessary for safe prescribing.

Recommendation 3:
Managers should ensure that drug allergies for all patients are specifically referenced in the patients' notes and their medication record.

It was apparent from the permanent ward staff we spoke with that there was commitment to providing good nursing care. While the ward was busy on the day of our visit, we observed positive, proactive engagement between patients and staff.

Of the 12 patients on the ward, 11 had been in the ward for less than six months; this was in keeping with our expectations that patients should spend relatively short periods of time in an IPCU. We did note that there was one patient who was considered a long-stay patient although this was a notable improvement, compared to our visit in 2021.

It was positive to hear that since our last visit, family members and named persons of patients were now routinely offered invitations to planned MDTs and they felt that communication regarding their relative's care had improved with by the responsible medical officer for the ward.

Patient records

Patient records were held mainly on EMIS, the electronic health record management system used by NHSGGC. Additional documents were stored in paper files, including nursing care plans. There is a long-term plan in NHSGCC for all patients records to be held on EMIS but there has been no exact date confirmed as to when this will take place. We look forward to hearing how this will be implemented.

We found patients' records easy to navigate, and there was a clear focus upon individual patients' mental and physical well-being, with a number of assessments based upon physical health. The risk assessments we reviewed were detailed, regularly reviewed, and we saw individual risk management plans included in the patients' records. There were weekly multidisciplinary team (MDT) meetings and regular reviews of care including input from pharmacy or other disciplines as and when required. We observed that the ward had a number of laptops available for nursing staff to use, in order to update records in 'real time'.

Nursing care plans

We had previously made recommendations about nursing care plans in the IPCU. The action plan received from the service in September 2022 confirmed that training and audits would be implemented to raise these standards. It was disappointing to find that on this visit, the quality of care plans we reviewed remained poor. Most care plans on file related to observation; they lacked a therapeutic or recovery focus, had no clear goals or outcomes for patients that would help them to move on from the ward. We found that some care plans were comprehensive, although these were for some of the longer stay patients. The majority of the plans had not been updated to reflect the current care needs. Many of the care plans lacked participation from the patients who were well enough to engage in the process. The care plans, with a few exceptions, had little personalisation and lacked any evidence of consistent reviews being undertaken. We believe that care plans should ensure participation and in order to support patients in the decision-making process, nursing staff should be able to evidence how they have made efforts to do this, and what goals that were that would be part of the care plan

that were clear and attainable. Furthermore, we would have liked to have seen how relatives were encouraged to participate with care planning and how their views were captured in the care planning process.

We heard from two relatives who felt the nursing team were welcoming, supportive and who told us that they felt listened to when speaking with staff. Had there been a record of those discussions, it would have allowed us to appreciate how care plans were based upon assessments, as well as discussions and input from people who knew the patient well. We discussed these issues with the senior charge nurse and charge nurse on the day and were advised of ongoing work in this area. We will look at this again on our next visit

Recommendation 4:
Managers should regularly audit care plans to ensure they are person-centred; include all the individual's needs; ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.

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

Use of mental health and incapacity legislation

On the day of our visit, all 12 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') as we would have expected in an IPCU setting. The majority 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 recorded appropriately with the correct forms in place.

We heard from patients that advocacy input to the ward was not as accessible compared to our previous visit and some patients were not aware of their rights as a result. This lack of advocacy input is a matter that will need addressed by managers to ensure patients are able to understand how their rights are protected and supported throughout their journey in the service.

Recommendation 5:
Managers should ensure that access to advocacy services is easily accessible for all patients.

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 advance statements for any patients in the IPCU. This was a cause for concern due to the length of stay and the gradual recovery for some of the patients. Speaking with staff there was no apparent promotion of advanced statements in the ward.

The Mental Welfare Commission has produced guidance on advanced statement which can be found at: https://www.mwcscot.org.uk/node/241

Recommendation 6:
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.

Rights and restrictions

The IPCU operated 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 detailed arrangements for time off the ward and support that was required to facilitate this safely.

We noted that for some of the patients who were subject to enhanced observation, this had been in place for an extended period of time. Improving Observation Practice guidance recommends that this 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 proactively conducted, although we heard from staff that enhanced observations were reviewed regularly.

Recommendation 7:
Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.

We were encouraged to hear of the ongoing work between the hospital in-patient services and their colleagues in the local authority. The bridge between hospital-based care and moving an individual either back home or into a supported living environment can be difficult to negotiate. With access to a discharge coordinator there was evidence of good communication between services and strategies have been put in place to aid transfers of care. We were aware of ongoing difficulties with sourcing community-based packages of care, however we are optimistic that with regular review meetings, patients will be less likely to remain in hospital unnecessarily.

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/

Activity and occupation

Activities for patients in IPCU wards were an issue due to the level of restrictions they face. We were pleased to hear of the work of the therapeutic activity nurse (TAN) employed to work flexibility with patients out with the routine 9am-5pm timetable. This role has ensured that there was an opportunity to offer activities to all patients.

During our visit we were able to observe a full list of daily activities in the ward. Patients spoke very positively of the TAN, "they are great, they help me do art, attend the walking group and other activities I really enjoy". We were able to find evidence of activity participation by patients in their notes. We were advised of the ongoing input supplied to the ward by occupational

therapy, physiotherapy and dietetic staff as and when required, on a one-to-one basis. It was positive to hear from patients of the continued benefit of accessing the recreational therapy (RT) unit in the hospital grounds. We were advised that due to the Covid-19 pandemic access to RT has continued to be restricted to one session per week for patients. We were informed by patients that they would like the number of weekly sessions increased as it aided with their recovery. We were pleased to observe that a recovery group had commenced for the ward and this was taking place during our visit.

The physical environment

The ward was a stark, aging environment with general wear and tear apparent throughout all areas of the ward. The basic decor of the ward did not provide for a positive experience for patients, with some requiring to sleep in dorms with fellow patients. The lack of en-suite facilities was raised by those patients that we spoke with.

The noise levels and the aging facilities were far from ideal for maximising patient care. We heard 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 heard from staff about the heat levels in some rooms, with them being too hot for patients to obtain a settled night's sleep. We were informed that there were plans to develop gardening activities for patients. During our visit the garden was littered with cigarette ends and whilst it was mid-winter it was not an environment that patients would have wished to use.

Recommendation 8:
Managers should develop a programme of works to update the current environment to ensure that it provides a conducive setting for patients.

Summary of recommendations

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Service response to recommendations

The Commission requires a response to this recommendation 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