Mental Welfare Commission for Scotland

Report on unannounced visit to:
Leverndale Hospital, Wards 5 & 6, Boulevard, Bute, and Campsie Wards, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 8 February 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 unannounced visit was carried out face-to-face.

Together, Wards 5 & 6, Boulevard, Bute, and Campsie Wards make up the low-secure forensic service for the Greater Glasgow and Clyde Health Board. The wards are based at Leverndale Hospital, which is located in the Crookston area of Glasgow.

- **Ward 5** provide low secure facilities for 15 men.
- **Ward 6** provide low secure facilities for 15 men.
- **Boulevard Ward** is a nine-bedded male 'pre-discharge' ward.
- **Bute Ward** provides a low-secure female provision for five women.
- **Campsie Ward** is a nine-bedded, male, low-security ward for forensic patients with a learning disability.

We last visited these wards on 23 and 24 February 2022; we made 10 recommendations during our visit to the managers. These included the need to address the re-opening of on-site facilities, medical staff ensuring patients are clear on their in-patient journey and discharge plans, the need to review the suitability of patients in Campsie Ward, addressing the inconsistencies found in MDT meetings and the recording of named person details, We also highlighted the need to improve staff knowledge in relation to the Adults with Incapacity (Scotland) Act 2000 as well as the understanding of how to manage patients under Part 4 of that Act. We recommended that managers should hold discussions with the local Health and Social Care Partnership to improve the provision of community activities for patients. In addition, we highlighted the restrictions around mealtimes in Wards 5 & 6.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and also look at ongoing care and treatment, plans for those patients currently awaiting discharge and the overall throughput of patients moving in and out of the low secure forensic setting.

Who we met with

We met with and reviewed the care and treatment of 19 patients across all of the wards that we visited. We met with senior managers of the service, the bed manager, psychiatry, psychology, senior charge nurses and several nursing staff in each of the wards. Unfortunately we were not able to speak to any carers, relatives or friends given that this was an unannounced visit. On the day of our visit all the wards except Bute and Campsie were full.

Commission visitors

Justin McNicholl, social work officer
Kathleen Taylor, engagement and participation officer
Douglas Seath, nursing officer
Anne Craig, social work officer
Mary Hattie, nursing officer
Susan Hynes, nursing officer
Margo Fyfe, senior manager

What people told us and what we found

Care, treatment, support and participation

This visit was unannounced, and as a result patients, relatives, and staff were not advised, or prepared to meet with the visiting officers. Despite this we were given full access to the wards to meet with patients and staff.

Patients expressed mostly positive views on their experiences. Patients were generally complimentary about the nursing care provided within the ward, describing the staff as "brand new", "excellent", "trustworthy" and "caring". One stated "they are like my family, they care for me and let me try new things that I have never done before." Most patients expressed the view that their nearest relative or named person had regular access to the care team and were able to ask open questions about their future care planning. A number of patients highlighted the positive aspect of having consistent staff whom they trusted and found to be approachable.

We heard that recruitment and retention of nursing staff was a challenge as staff tended to move on from the service, compared to previous years when staff tended to maintain their positions in the wards. Despite this, the use of regular bank staff ensured that patients knew the staff who would be supporting them during each shift. It was positive to note that no agency staff are deployed to the wards due to the risk management profile of the patient group.

We were able to observe patients medication charts which illustrated the low use of as required medication for the majority of patients. This finding was positive to note as patients and staff reported the steps taken to utilise de-escalation techniques initially and only using medication as a last resort. It was also positive to note the low use of enhanced observations for those patients who require this. On the day of the visit two patients were on enhanced observations.

We were able to observe good social interactions between all patients and staff. In addition, we noted that the wards were busy with a range of professional visitors, and patients coming and going to attend community placements or take physical exercise. We were able to speak to patients in all the wards, who reported the opportunities to have time out in the grounds of the hospital, as well as in the wider community. We heard from some patients that they had regular access to on-site and off-site community groups, which is a notable improvement compared to our last visit, when some patients were still restricted due to Covid-19. Activities included attendance at college courses, creative writing courses, newspaper groups, gym access, and jewellery making via the occupational therapy staff. Patients praised the recreational therapy (RT) unit based in the hospital grounds that allowed patients to have "safe space" to complete a variety of activities. One patient showed us a piece of art they had undertaken which took pride of place in their bedroom.

In all wards, we found activity timetables, which detailed a weekly structure for most patients. This timetable approach fitted well with the home-style model which has had significant success, in the Boulevard and Bute wards, in preparing patients for returning to the community. The home-style model of care works in a recovery-based framework; staff and patients work together to ensure that each individual is equipped with the practical skills required to allow them the optimal chance of successful rehabilitation, from the long-term in-

patient forensic setting to an identified community setting. One patient noted, “I am ready to live my life in the community thanks to how this place works.”

Patients and staff spoke positively about their access to social work staff from the local health and social care partnership (HSCP); patients had access to social care staff or support workers in the community that enabled timely discharges from hospital. This appears to have improved since our previous visit, when patients were expressing significant frustration around the delays they were experiencing. For this visit, we were informed that there were seven patients across the services whose discharge from hospital was delayed; the longest delay dated back to April 2021, although this patient has since being provided with clear discharge planning and community provisions. The majority of delays were no longer than six months, mainly due to difficulties in sourcing suitable supported accommodation.

All patients in the low secure wards were subject to the care programme approach (CPA), a multi-disciplinary care management process. This approach is coordinated by a member of staff onsite, which ensures that these take place consistently and recordings are of a high standard. There was evidence of patients, relatives and advocacy staff participating in these meetings as well as social workers who were mental health officers. Thorough assessment paperwork was prepared prior to each meeting that included patient views. Care management plans and risk assessment documentation were also on record. The CPA minutes were detailed and gave a clear indication of future plans for each patient. All of the CPA documentation was kept in paper form.

We were pleased to note that the ward has a well-represented multi-disciplinary team (MDT) including psychiatry, nursing, occupational therapy, psychology and other professions as and when required. However recording of the MDT meetings were inconsistent, and on occasions, psychiatry and nursing staff were met on their own and recorded these meetings as an MDT when there are no other professionals present. Some of the MDT meeting recordings did not appear dynamic and were repetitive, with limited evidence on whether or not patients were meeting their identified outcomes. Some MDT meeting records did not note who was present at these meetings. The MDT meetings, unlike the CPA process, did not demonstrate any forward planning on many of the patients’ journeys. We heard from a number of patients and staff across the wards that there is a “blanket approach”, in that patients were not invited to their MDT meetings in the low secure setting. This was reflected in the limited participation by patients in the decision-making around their future care planning. It was disappointing to note these findings were a recommendation during our last visit. We are therefore recommending again that managers review how the MDT meetings are held, recorded and that they ensure maximum participation for patients in the decision-making that affects them.

Recommendation 1:
Managers should ensure that patients are invited to the weekly MDT meeting. Patient and staff attendance should be recorded on the MDT meeting form alongside a summary of any discussion with the patient. If a patient declines to attend the meeting, the reasons for this should be recorded.

We were pleased to hear from psychology services during our visit. This highlighted the important role this discipline has in contributing to reflective practice, low intensity CBT

training and with complex case reviews. Staff informed us that psychology input to the wards was “invaluable” and “helped to support the staff group”.

We heard from one patient regarding a safeguarding concern. This patient was signposted to the appropriate agencies to discuss these matters further which would ensure if any particular actions are required that these are progressed.

Patient records
Patient records are held mainly on EMIS, the electronic health record management system used by NHSGGC. Additional documents continue to be collated 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 no exact date has been confirmed for transition to a paperless system. We look forward to hearing how this will be implemented for the wards. We found patients’ records easy to navigate, and there was a clear focus on individual patients’ mental and physical well-being, with comprehensive physical health reviews in place. The HCR-20 risk assessments we read were detailed, regularly reviewed, and we saw clear individual risk management plans included in the patients’ records. Additionally, there was clear evidence of multi-agency public protection arrangements (MAPPA) and where applicable, input with the principle medical officer (PMO) who holds an important role in the management of forensic patients.

Nursing care plans
During this visit we examined care plans across all of the wards. Many of the care plans in Bute Ward and Boulevard were well-written and provided clear goals for patients. However, the care plan reviews were not person-centred and there was no consistency in when these should be reviewed by staff. The reviews dates varied widely. Some care plans were noted to be comprehensive, particularly for the longer-stay patients, however the majority of the plans had not been updated to reflect the current care needs observed. With a few exceptions, the care plans lacked personalisation. We believe that care plans should ensure participation and to support decision-making, and nursing staff should be able to evidence how they have made efforts to do this. Furthermore, we would have liked to have seen how relatives were supported to participate with care planning and how their views were captured in the care planning process.

Recommendation 2:
Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that 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 50 of the patients in the wards 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 a low secure environment. The appropriate detention paperwork was readily available for all patients.

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.

Patients we spoke to have a good knowledge of their legal status and rights; they also had advocacy support and legal representation. We found no issues regarding the required legal paperwork.

Some patients across the wards are subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). In relation to the patients' welfare benefits, this meant that the NHS had applied to the department of work and pensions (DWP) for appointeeship, in order to manage patients' welfare benefits. No concerns were raised with us from patients whose funds were being managed by the hospital.

The patients in Campsie Ward had an established diagnoses of learning disability, and a number of these patients lacked capacity in relation to their medical treatment. For those patients, a section 47 certificate under AWI was required to authorise their medical treatment. During our visit, none of the available staff could find any s47 certificates that had issued for the patients.

Recommendation 3:
Managers must ensure that where a patient lacks capacity in relation to decisions about medical treatment s47 certificates, and where necessary, treatment plans are completed in accordance with the AWI Code of Practice and cover all relevant medical treatment the individual is receiving.

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 clear evidence of advance statements on file for patients and in general, there was awareness of these documents. Speaking with staff, we were pleased to find that there was clear understanding of, and the promotion of, advanced statements across the wards.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. All patients on the wards were designated as 'specified persons' in relation to safety and security provisions. This has been raised with managers on previous visits and we have been assured that each patient's specification is reviewed on a three monthly basis, in line with their individual management plans. Despite this assurance, during our visit we could have no evidence of any reasoned opinion. Registered medical officers are required to notify the commission on the grounds for the use of specified persons. Managers and psychiatry staff were clear that all patients required to be individually designated as specified persons for the protection of patients and staff in these wards.

Recommendation 4:
Managers should ensure specified persons procedures are implemented with the appropriate completion of reasoned opinions for all patients.

Patients had access to advocacy and the wards had regular input from Circles advocacy, a specialist forensic advocacy service. As well as individual work, Circles held meetings on the wards to help patients with collective issues. We did not hear from advocacy during this visit, however look forward to linking in them with on future visits regarding the input they provide to ensuring patients are supported with their rights whilst within the low-secure setting.

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 the low secure wards are critical as they transition back to the community. We heard of good levels of activity both on and out with the wards; generally patients that we spoke to seemed content with the actives that were available to them. Activities were based on personal choice and were recovery-focused. Use of the onsite recreational therapy (RT) unit in the hospital grounds was praised by patients as well as access to ward based gardening opportunities. There were good links with further education and employment projects. We heard that there continued to be difficulties for patients, particularly new patients, with no time off the ward. These patients relied more on the 'on ward' activities. We found good evidence of a range of activities for these patients. Some patients were able to tell us about their activities and the groups they attended, and how they enjoyed these. Some of the wards have access to a pool table which the patients reported enjoying. It was good to see the importance of therapeutic activities in patient's care and treatment. Staff told us that a patient group on the Leverndale site was putting together a "Leverndale life" pathway and leaflet to aid fellow patients with journeys in the hospital. We also heard during interviews with the patients, that they enjoyed the opportunity to meet and plan the activities for the up-and-coming week in their respective wards.

The physical environment

The physical environment of the wards was unchanged since our last visit. No patients raised any concerns about the lay out of the wards.

Bute ward offered a pleasant environment for patients who found it to be homely and comfortable despite the fact that there are no en-suite facilities available. All wards have access to a number of lounges. The gardens in the wards were found to be in a reasonable state of repair and easily accessible for patients. The management team acknowledged that the space in Campsie Ward remains limited, and the environment could be challenging, especially during periods of time when a patient may become stressed, distressed or when patients with mobility issues are at risk of falls. In our last visit report we noted that the narrow main corridor in Campsie is not ideal for the patient group. It was reported that occupational therapy and physiotherapy staff remain concerned about the layout of the ward. The management team expressed the view that both Campsie and Bute wards are not bespoke or

designed for the complex needs of the patient group. They informed us of steps taken to escalate the need for a suitable ward environment for these patients; there has been limited success due to the lack of budgetary support for redesigning these wards. Despite this, we heard of plans to review the frequency of falls and the risks associated in Campsie Ward, due to the patient group.

Any other comments

Food

During out last a number of patients raised issues regarding the food, the portion sizes and the being “fed-up” with the menu rotation. On this occasion we only heard from two patients regarding their negative experience of food provided, advising that they had been supplied undercooked and “raw” chips as part of their main meal. We will be discussing these experiences with managers following our visit.

Summary of recommendations

Recommendation 1:
Managers should ensure that patients are invited to the weekly MDT meeting. Patient and staff attendance should be recorded on the MDT meeting form alongside a summary of any discussion with the patient. If a patient declines to attend the meeting, the reasons for this should be recorded.

Recommendation 2:
Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that 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.

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Managers must ensure that where a patient lacks capacity in relation to decisions about medical treatment S47 certificates, and where necessary, treatment plans are completed in accordance with the AWI Code of practice and cover all relevant medical treatment the individual is receiving.

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Service response to recommendations

The Commission requires a response to these recommendations within three months of receipt 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

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